96TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPT. No. 96-589
Part 2

MEDICARE AND MEDICAID AMENDMENTS OF 1980

REPORT

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

U.S. HOUSE OF REPRESENTATIVES

TO ACCOMPANY

H.R. 4000

[Including Cost Estimate and Comparison of Congressional Budget Office]

APRIL 23, 1980.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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APRIL 23, 1980.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. STAGGERS, from the Committee on Interstate and Foreign Commerce, submitted the following

REPORT

[To accompany H.R. 4000 which on May 8, 1979, was referred jointly to the Committee on Ways and Means and the Committee on Interstate and Foreign Commerce]

[Including cost estimate and comparison of the Congressional Budget Office]

The Committee on Interstate and Foreign Commerce, to whom was referred the bill (H.R. 4000) to amend the Social Security Act with respect to health programs authorized under it, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

SHORT TITLE; TABLE OF CONTENTS

SECTION 1. This Act may be cited as the "Medicare and Medicaid Amendments of 1980".

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EXPANDED MEMBERSHIP OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 2. Section 1152(b)(1)(A) of the Social Security Act is amended—

(1) by inserting "and, if the organization so elects, of other health care practitioners engaged in the practice of their professions in such area who hold independent hospital admitting privileges," after the comma in clause (ii); and

(2) by inserting "(except as otherwise provided under section 1155(c))" after "does not" in clause (vi).

REGISTERED NURSE AND DENTIST MEMBERSHIP ON STATEWIDE COUNCIL ADVISORY GROUP

SEC. 3. (a) Section 1162(e)(1) of the Social Security Act is amended by inserting "(including at least one registered professional nurse and at least one doctor of dental surgery or of dental medicine)" after "representatives".

(b) The amendment made by this section shall become effective 180 days after the date of the enactment of this Act.

NONPHYSICIAN MEMBERSHIP ON NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL

SEC. 4. (a) Section 1163(a)(1) of the Social Security Act is amended by inserting "one doctor of dental surgery or of dental medicine, one registered professional nurse, and one other health practitioner (other than a physician as defined in section 1861(r)(1)),," after "physicians,".

(b) Section 1163(a)(2) of such Act is amended by striking out "four members" and inserting "five members" in lieu thereof.

(c) Section 1163(a)(3) of such Act is amended by inserting "physician" before "members".

(d) Section 1163(b) of such Act is amended by striking out "Members" and inserting in lieu thereof "Physician members".

(e) Section 1173 of such Act is amended by striking out "(except sections 1155(c) and 1163)" and inserting in lieu thereof "(except section 1155(c))".

(f) The amendments made by this section shall become effective 180 days after the date of the enactment of this Act.

EFFICIENCY IN DELEGATED REVIEW

SEC. 5. Section 1155(e) of the Social Security Act is amended by striking out "effectively and in timely fashion" and inserting in lieu thereof "effectively, efficiently, and in timely fashion".

REQUIRED ACTIVITIES OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 6. (a)(1) Subsection (b) of section 1154 of the Social Security Act is amended—

(A) by striking out "in addition to review of health care services provided by or in institutions, only such of the duties and functions required under

this part of Professional Standards Review Organization as he determines such organization to be capable of performing" in the first sentence and inserting in lieu thereof "in addition to review of health care services (other than ancillary, ambulatory care, and long-term care services) provided by or in hospitals, only such of the duties and functions as he requires the organization to perform under subsection (f)(2) or subsection (f)(4) and which the organization is capable of performing", and

(B) by striking out "only if the Secretary finds that is is substantially carrying out in a satisfactory manner, the activities and functions required of Professional Standards Review Organizations under this part with respect to the review of health care services provided by or in institutions (including ancillary services) and, in additon, review of such other health care services as the Secretary may require" in the second sentence and inserting in lieu thereof "only if the Secretary finds that it is substantially carrying out in a satisfactory manner, the activities and functions required of that Professional Standards Review Organization under this part".

(2) Subsection (c) of such section is amended by inserting "of that organization" after "required under this part".

(3) Such section is further amended by adding at the end the following new subsection:

"(f)(1) The Secretary shall establish a program (hereinafter in this subsection referred to as the 'program') for the evaluation of the cost-effectiveness of review of particular health care services by Professional Standards Review Organizations.

"(2) In order to demonstrate the cost-effectiveness of requiring review of particular health care services before such review is generally required, the program shall be designed in a manner so that the Secretary will require particular Professional Standards Review Organizations, chosen by a statistically valid method that will permit a valid evaluation of the cost-effectiveness of such review, to review particular health care services.

"(3) The program shall provide for the evaluation of cost-effectiveness of the review of particular health care services under the program, particularly in comparison with areas in which such review was not required or performed.

"(4) Based upon such evaluation, or upon an evaluation of comparable statistical validity, and a finding that review of particular health care services is cost-effective or yields other significant benefits, the Secretary shall specify such particular health care services which Professional Standards Review Organizations (either generally or under such conditions and circumstances as the Secretary may specify) have the duty and function of reviewing under this part.

"(5) For purposes of this subsection, the term 'particular health care services' does not include health care services (other than ancillary, ambulatory care, and long-term care services) provided by or in hospitals.".

(b) Section 1155(a) of such Act is amended—

(1) by striking out "at the earliest date practicable" in paragraph (1) and inserting in lieu thereof "to the extent and at the time specified by the Secretary under section 1154(f)";

(2) by inserting ", consistent with section 1154(f)," in paragraph (7)(A) after "only"; and

(3) by inserting "(consistent with section 1154(f))" in paragraph (7)(B) after "to the extent".

(c) Section 1155 of such Act is amended by striking out subsection (g).

(d) Section 1155 of such Act is amended by adding at the end thereof the following new subsection:

"(h) If the Secretary has designated an organization (other than under section 1154) as a Professional Standards Review Organization, but that organization has not assumed responsibility for the review of particular activities in its area included in subsection (a)(1), the Secretary may designate another qualified Professional Standards Review Organization (in reasonable proximity to the providers and practitioners whose services are to be reviewed) to assume the responsibility for the review of some or all of those particular activities.".

RESPONSE OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS TO FREEDOM OF INFORMATION ACT REQUESTS

SEC. 7. No Professional Standards Review Organization designated (conditionally or otherwise) under part B of title XI of the Social Security Act shall

be required to make available any records pursuant to a request made under section 552 of title 5, United States Code, until the end of the 180 day period beginning on the date of entry of a final court order requiring that such records be made available.

CONSULTATION BY PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS WITH HEALTH CARE PRACTITIONERS

SEC. 8. (a) Section 1155(a) of the Social Security Act is amended by adding at the end thereof the following new paragraph:

"(8) Each Professional Standards Review Organization shall consult (with such frequency and in such manner as may be prescribed by the Secretary) with representatives of health care practitioners (other than physicians described in section 1861(r)(1)) and of institutional and noninstitutional providers of health care services, in relation to the Professional Standards Review Organization's responsibility for the review under paragraph (1) of the professional activities of such practitioners and providers.".

(b) Section 1162(e) of such Act is amended by striking out the first parenthetical material in paragraph (1) and the parenthetical material in paragraph (2).

(c) The amendments made by this section shall become effective 180 days after the date of enactment of this Act.

REVIEW OF ROUTINE HOSPITAL ADMISSION SERVICES AND PREOPERATIVE HOSPITAL STAYS BY PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 9. Section 1155(a)(2) of the Social Security Act is amended to read as follows:

"(2) Each Professional Standards Review Organization shall have the authority to determine, in advance, in the case of—

"(A) any elective admission to a hospital or other health care facility (including admission occurring on weekends),

"(B) any routine diagnostic services furnished in connection with such an admission, and

"(C) any other health care service which will consist of extended or costly courses of treatment,

whether such service, if provided, or if provided by a particular health care practitioner or by a particular hospital or other health care facility, organization, or agency, would meet the criteria specified in subparagraphs (A) and (C) of paragraph (1).".

STUDY OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS NORMS, STANDARDS, AND CRITERIA

SEC. 10. The Secretary of Health, Education, and Welfare shall, in consultation with the National Professional Standards Review Council, conduct a nationwide study of the differences in medical criteria and length-of-stay norms utilized by Professional Standards Review Organizations in the various regions of the country. The study shall include an assessment of the rationale that contributes to these regional differences. The Secretary shall report the findings and conclusions made with respect to the study to the Congress within one year of the date of the enactment of this Act.

NONPROFIT HOSPITAL PHILANTHROPY

SEC. 11. (a) Part A of title XI of the Social Security Act is amended by adding after section 1131 the following new section:

"ENCOURAGEMENT OF NON-PROFIT HOSPITAL PHILANTHROPY

"SEC. 1132. (a) It is the policy of the United States that philanthropic support for health care be encouraged and expanded, especially in support of experimental and innovative efforts to improve the health care delivery system.

"(b) For purposes of determining under titles V, XVIII, and XIX the reasonable costs of services furnished by non-profit hospitals, unrestricted grants, gifts, and income from endowments shall not be deducted from any operating costs of

such hospitals, and, in addition, the following items shall not be deducted from any operating costs of such hospitals:

"(1) A donor designated or restricted grant, gift, or income from an endowment, as defined in section 405.423(b)(2) of title 42 of the Code of Federal Regulations.

"(2) An unrestricted grant or gift, or income from such a grant or gift, which is not available for use as operating funds because of its designation by the hospital's governing board.

"(3) A grant or similar payment which is made by a governmental entity and which is not available, under the terms of the grant or payment, for use as operating funds.

"(4) The sale or mortgage of any real estate or other capital assets of the hospital which the hospital acquired through a gift or grant and which is not available for use as operating funds under the terms of the gift or grant or because of its designation by the hospital's governing board, except for recovery of the appropriate share of gains and losses realized from the disposal of depreciable assets.

"(5) A sinking fund which is (A) created by the hospital in order to meet a condition imposed by a third party for the third party's financing of a capital improvement of the hospital, and which fund is used exclusively to make payments to such third party for the financing of the capital improvement.".

(b) Subsection (b) of section 1132 of the Social Security Act (as added by subsection (a)) shall apply to grants, gifts, and endowments made or established on or after the date of the enactment of this Act.

CONSULTATIVE SERVICES FOR SKILLED NURSING FACILITIES

SEC. 12. Section 1864(a) of the Social Security Act is amended by striking out the third and fourth sentences.

STUDY OF NEED FOR DUAL PARTICIPATION OF SKILLED NURSING FACILITIES

SEC. 13. (a)(1) The Secretary of Health, Education, and Welfare shall conduct a study of the availability and need for skilled nursing facility services covered under part A of title XVIII of the Social Security Act and under State plans approved under title XIX of such Act.

(2) Such study shall include—

(A) an investigation of the desirability and feasibility of imposing a requirement that skilled nursing facilities (i) which furnish services to patients covered under State plans approved under title XIX of the Social Security Act also furnish such services to patients covered under part A of title XVIII of such Act, and (ii) which furnish services to patients covered under such title XVIII also to furnish such services to patients covered undner such State plans,

(B) an evaluation of the impact of existing laws and regulations on skilled nursing facilities and individuals covered under such State plans and under part A of such title XVIII, and an evaluation of the extent to which existing laws and regulations encourage skilled nursing facilities to accept only title XVIII beneficiaries or title XIX recipients, and

(C) an investigation of possible changes in regulations and legislation which would result in encouraging a greater availability of skilled nursing facility services.

(3) In developing such study, the Secretary shall consult with professional organizations, health experts, private insurers, nursing home providers, and consumers of skilled nursing facility services.

(b) Within one year after the date of enactment of this Act the Secretary shall complete such study and shall submit to the Congress a full and complete report thereon, together with recommendations with respect to the matters covered by such study (including any recommendations for administrative or legislative changes).

ALTERNATIVE TO DECERTIFICATION OF LONG-TERM CARE FACILITIES OUT OF COMPLIANCE WITH CONDITIONS OF PARTICIPATION; LOOK BEHIND AUTHORITY

SEC. 14. (a) Section 1866 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(f)(1) Where the Secretary determines that a skilled nursing facility which has filed an agreement pursuant to subsection (a)(1) or which has been certified for participation in a plan approved under title XIX no longer substantially meets the provisions of section 1861(j), and further determines that the facility's deficiencies—

"(A) immediately jeopardize the health and safety of its patients, the Secretary shall provide for the termination of the agreement or of the certification of the facility and shall provide, or

"(B) do not immediately jeopardize the health and safety of its patients, the Secretary may, in lieu of terminating the agreement or certification of the facility, provide

that no payment shall be made under this title (and order a State agency established or designated pursuant to section 1902(a)(5) of this Act to administer or supervise the administration of the State plan under title XIX of this Act to deny payment under title XIX) with respect to any individual admitted to such facility after a date specified by him.

"(2) The Secretary shall not make such a decision with respect to a facility until such facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the provisions of section 1861(j), to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

"(3) The Secretary's decision to deny payment may be made effective only after such notice to the public and to the facility as may be prescribed in regulations, and its effectiveness shall terminate (A) when the Secretary finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the provisions of section 1861(j), or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of section 1861(j) on the date specified in such clause, the Secretary shall terminate such facility's agreement or provide for termination of such facility's certification, notwithstanding the provisions of paragraph (2) of subsection (b), effective with the first day of the first month following the month specified in such clause.".

(b)(1)(A) Section 1902 of such Act is amended by adding at the end the following new subsection:

"(h)(1) In addition to any other authority under State law, where a State determines that a skilled nursing facility or intermediate care facility which is certified for participation under its plan no longer substantially meets the provisions of section 1861(j) or section 1905(c), respectively, and further determines that the facility's deficiencies—

"(A) immediately jeopardize the health and safety of its patients, the State shall provide for the termination of the facility's certification for participation under the plan and may provide, or

"(B) do not immediately jeopardize the health and safety of its patients, the State may, in lieu of providing for terminating the facility's certification for participation under the plan, provide

that no payment will be made under the State plan with respect to any individual admitted to such facility after a date specified by the State.

"(2) The State shall not make such a decision with respect to a facility until the facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the provisions of section 1861(j) or section 1905(c) (as the case may be), to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

"(3) The State's decision to deny payment may be made effective only after such notice to the public and to the facility as may be provided for by the State, and its effectiveness shall terminate (A) when the State finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the provisions of section 1861(j) or section 1903(c) (as the case may be), or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of the respective section on the date specified in such clause, the State shall terminate such facility's certification for participation under the plan effective with the first day of the first month following the month specified in such clause.".

(B) Such section is further amended by inserting before the semicolon at the end of subsection (a)(33)(B) the following: ", except that the Secretary is authorized to validate State determinations and, on that basis, make independent and binding determinations concerning the extent to which individual institutions and agencies meet the requirements for participation".

(2) Section 1910 of such Act is amended by adding at the end thereof the following new subsection:

"(c)(1) The Secretary may cancel approval of any skilled nursing or intermediate care facility at any time if he finds on the basis of a determination made by him as provided in section 1902(a)(33)(B) that a facility fails to meet the requirements contained in section 1902(a)(28) or section 1905(c), or if he finds grounds for termination of his agreement with the facility pursuant to section 1866(b). In that event the Secretary shall notify the State agency and the skilled nursing facility or intermediate care facility that approval of eligibility of the facility to participate in the programs established by this title and title XVIII shall be terminated at a time specified by the Secretary. The approval of eligibility of any such facility to participate in such programs may not be reinstated unless the Secretary finds that the reason for termination has been removed and there is reasonable assurance that it will not recur.

"(2) Any skilled nursing facility or intermediate care facility which is dissatisfied with a determination by the Secretary that it no longer qualifies as a skilled nursing facility or intermediate care facility for purposes of this title, shall be entitled to a hearing by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). Any agreement between such facility and the State agency shall remain in effect until the period for filing a request for a hearing has expired or, if a request has been filed, until a decision has been made by the Secretary; except that the agreement shall not be extended if the Secretary makes a written determination, specifying the reasons therefor, that the continuation of provider status constitutes an immediate and serious threat to the health and safety of patients, and the Secretary certifies that the facility has been notified of its deficiencies and has failed to correct them.".

LIFE SAFETY CODE REQUIREMENTS

SEC. 15. Section 1861(j)(13) of the Social Security Act is amended by striking out all that precedes the first semicolon and inserting in lieu thereof "meets such provisions of such edition (as is specified by the Secretary in regulations) of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes".

CRIMINAL STANDARDS FOR CERTAIN MEDICARE- AND MEDICAID-RELATED CRIMES

SEC. 16. Paragraphs (1) and (2) of section 1877(b) and of section 1909(b) of the Social Security Act are each amended by inserting "knowingly and willfully" after "Whoever".

EXCLUSION OF HEALTH CARE PROFESSIONALS CONVICTED OF MEDICARE- OR MEDICAID-RELATED CRIMES

SEC. 17. (a) Title XI of the Social Security Act is amended by adding after section 1126 the following new section:

"EXCLUSION OF CERTAIN INDIVIDUALS CONVICTED OF MEDICARE- OR MEDICAID-RELATED CRIMES

"SEC. 1127. (a) Whenever the Secretary determines that a physician or other individual has been convicted (on or after October 25, 1977, or within such period prior to that date as the Secretary shall specify in regulations) of a criminal offense related to such individual's participation in the delivery of medical care or services under title XVIII or title XIX, the Secretary—

"(1) shall bar from participation in the program under title XVIII, for such period as he may deem appropriate, each such individual otherwise eligible to participate in such program;

"(2)(A) shall promptly notify each appropriate State agency administering or supervising the administration of a State plan approved under title XIX, of the fact and circumstances of such determination, and (except as provided in subparagraph (B)) require each such agency to bar such indi-

vidual from participation in such program for such period as he shall specify which in the case of an individual specified in paragraph (1) shall be the period established pursuant to paragraph (1);

"(B) may waive the requirement under subparagraph (A) to bar an individual from participation in a State plan program under title XIX, where he receives and approves a request for such a waiver with respect to that individual from the State agency administering or supervising the administration of such plan; and

"(3) shall promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of such individual of the fact and circumstances of such determination, request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and request that such State or local agency or authority keep the Secretary and the Inspector General of the Department of Health, Education, and Welfare fully and currently informed with respect to any actions taken in response to such request.

"(b) A determination made by the Secretary under this section shall be effective at such time and upon such reasonable notice to the public and to the person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of inpatient hospital services, post-hospital extended care services, and home health services furnished under title XVIII, such determination shall be effective in the manner provided in paragraphs (3) and (4) of section 1866(b) with respect to terminations of agreements), and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

"(c) Any person who is the subject of an adverse determination made by the Secretary under subsection (a) shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g)".

(b) Section 1862(e) of such Act is amended to read as follows:

"(e) No payment may be made under this title with respect to any item or service furnished by a physician or other individual during the period when he is barred pursuant to section 1127 from participation in the program under this title.".

(c) Section 1902(a)(39) of such Act is amended to read as follows:

"(39) provide that the State agency shall bar any specified individual from participation in the program under the State plan for the period specified by the Secretary, when required by him to do so pursuant to section 1127, and provide that no payment may be made under the plan with respect to any item or service furnished by such individual during such period; and".

(d) Section 1902(g) of such Act is repealed.

REQUIREMENTS CONCERNING REPORTING OF FINANCIAL INTEREST

SEC. 18. (a) Section 1124(a)(3)(A)(ii) of the Social Security Act is amended to read as follows:

"(ii) is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof, which whole or part interest is equal to or exceeds $25,000 or 5 per centum of the total property and assets of the entity; or".

(b) Section 1902(a)(35) of such Act is amended to read as follows:

"(35) provide that any disclosing entity (as defined in section 1124(a)(2)) receiving payments under such plan complies with the requirements of section 1124;".

WITHHOLDING OF FEDERAL SHARE OF PAYMENTS TO MEDICAID PROVIDERS TO RECOVER MEDICARE OVERPAYMENTS

SEC. 19. (a) Subparagraphs (D) and (E) of section 1902(a)(13) of the Social Security Act are each amended by inserting "(except where the State agency is subject to an order under section 1913)" after "payment".

(b) Section 1903(a)(1) of such Act is amended by striking out "subject to subsections (g) and (h)" and inserting in lieu thereof "subject to subsections (g), (h), and (j)".

(c)(1) Section 1903(j) of such Act is amended to read as follows:

"(j) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter shall be adjusted in accordance with section 1913.".

(2) Section 1903(n) of such Act is amended by striking out "or is subject to a suspension of payment order issued under subsection (j)".

(d) Title XIX of such Act is amended by adding at the end the following new section:

"WITHHOLDING OF FEDERAL SHARE OF PAYMENTS FOR CERTAIN MEDICARE PROVIDERS

"SEC. 1913. (a) The Secretary may adjust, in accordance with this section, the Federal matching payment to a State with respect to expenditures for medical assistance for care or services furnished in any quarter by—

"(1) an institution (A) which has or previously had in effect an agreement with the Secretary under section 1866; and (B)(i) from which the Secretary has been unable to recover overpayments made under title XVIII, or (ii) from which the Secretary has been unable to collect the information necessary to enable him to determine the amount (if any) of the overpayments made to such institution under title XVIII; and

"(2) any person (A) who (i) has previously accepted payment on the basis of an assignment under section 1842(b)(3)(B)(ii), and (ii) during the annual period immediately preceding such quarter submitted no claims for payment under title XVIII, or submitted claims for payment under title XVIII which aggregated less than the amount of overpayments made to him, and (B)(i) from whom the Secretary has been unable to recover overpayments received in violation of the terms of such assignment, or (ii) from whom the Secretary has been unable to collect the information necessary to enable him to determine the amount (if any) of the overpayments made to such person under title XVIII.

"(b) The Secretary may (subject to the remaining provisions of this section) reduce payment to a State under this title for any quarter by an amount equal to the lesser of the Federal matching share of payments to any institution or person specified in subsection (a), or the total overpayments to such institution or person under title XVIII, and may require the State to reduce its payment to such institution or person by such amount.

"(c) The Secretary shall not make any adjustment in the payment to a State, nor require any adjustment in the payment to an institution or person, pursuant to subsection (b) until after he has provided adequate notice (which shall be not less than 60 days) to the State agency and the institution or person.

"(d) The Secretary shall by regulation provide procedures for implementation of this section, which procedures shall (1) determine the amount of the Federal payment to which the institution or person would otherwise be entitled under this section which shall be treated as a setoff against overpayments under title XVIII, and (2) assure the restoration to the institution or person of amounts withheld under this section which are ultimately determined to be in excess of overpayments under title XVIII and to which the institution or person would otherwise be entitled under this title.

"(e) The Secretary shall restore to the trust funds established under sections 1817 and 1841, as appropriate, amounts recovered under this section as setoffs against overpayments under title XVIII.

"(f) Notwithstanding any other provision of this title, an institution or person shall not be entitled to recover from any State any amount in payment for medical care and services under this title which is withheld by the State agency pursuant to an order by the Secretary under subsection (b).".

HOSPITAL PROVIDERS OF LONG-TERM CARE SERVICES ("SWING-BEDS")

SEC. 20. (a)(1) Title XVIII of the Social Security Act is amended by adding the following new section at the end thereof:

"HOSPITAL PROVIDERS OF EXTENDED CARE SERVICES

"SEC. 1882. (a)(1) Any hospital (other than a hospital which has in effect a waiver of the requirement imposed by section 1861(e)(5)) which has an agreement under section 1866 may (subject to subsection (b)) enter into an agreement with the Secretary under which its inpatient hospital facilities may be used for the furnishing of services of the type which, if furnished by a skilled nursing facility, would constitute post-hopsital extended care services.

"(2)(A) Notwithstanding any other provision of this title, payment to any hospital for services furnished under an agreement entered into under this section shall be based upon the reasonable cost of the services as determined under subparagraph (B).

"(B)(i) The reasonable cost of the services consists of the rasonable cost of routine services (determined under clause (ii)) and the reasonable cost of ancillary services (determined under clause (iii)).

"(ii) The reasonable cost of routine services furnished during any calendar year by a hospital under an agreement under this section is equal to the product of (I) the number of patient days during the year for which the services were furnished, and (II) the average reasonable cost per patient-day, such average reasonable cost per patient-day being the average rate per patient-day paid for routine services during the previous calendar year under title XIX to skilled nursing facilities located in the State in which the hospital is located and which have agreements entered into under section 1902(a)(28).

"(iii) The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

"(b) The Secretary may not enter into an agreement under this section with any hospital unless the hospital has been granted a certificate of need for the provision of long-term care services from the State health planning and development agency (designated under section 1521 of the Public Health Service Act) for the State in which the hospital is located.

"(c) An agreement with a hospital under this section shall, except as otherwise provided under regulations of the Secretary, be subject to termination on the same conditions as are agreements with skilled nursing facilities under section 1866 (unless the hospital fails to satisfy the requirements specified in subsection (b)) and shall, where not inconsistent with any provision of this section, impose the same duties, responsibilities, conditions, and limitations, as those imposed under such agreements entered into under section 1866; except that no such agreement with any hospital shall be in effect for any period during which the hospital does not have in effect an agreement under section 1866, or where there is in effect for the hospital a waiver of the requirement imposed by section 1861(e)(5). A hospital whose agreement under this section has been terminated shall not be eligible to undertake a new agreement until a two-year period has elapsed from the termination date.

"(d) Any agreement with a hospital under this section shall provide that payment for services will be made only for services for which payment would be made as post-hospital extended care services if those services had been furnished by a skilled nursing facility under an agreement entered into under section 1866; and any individual who is furnished services, for which payment may be made under an agreement under this section, shall, for purposes of this title (other than this section), be deemed to have received post-hospital extended care services in like manner and to the same extent as if the services furnished to him had been post-hospital extended care services furnished by a skilled nursing facility under an agreement under section 1866.

"(e) During a period for which a hospital has in effect an agreement under this section, in order to allocate routine costs between hospital and long-term care services for purposes of determining payment for inpatient hospital service, the total reimbursement received for routine services from all classes of long-term care patients (including title XVIII, title XIX, and private pay patients) shall be subtracted from the hospital's total routine costs before calculations are made to determine title XVIII reimbursement for routine hospital services.

"(f) A hospital which enters into an agreement with the Secretary under this section shall be required to meet those conditions applicable to skilled nursing facilities relating to discharge planning and the social services function (and staffing requirements to satisfy it) which are promulgated by the Secretary under

section 1861(j)(15). Services furnished by such a hospital which would otherwise constitute post-hospital extended care services if furnished by a skilled nursing facility shall be subject to the same requirements applicable to such services when furnished by a skilled nursing facility except for those requirements the Secretary determines are inappropriate in the case of these services being furnished by a hospital under this section.

"(g) The Secretary shall prescribe by regulation an alternative method for determining the amount of the reasonable cost of post-hospital extended care services furnished in a distinct part of a hospital certified as a skilled nursing facility under section 1861(j) that is the same method as the method prescribed in subsections (a) and (e) for determining the amount of the reasonable cost for such services furnished by a hospital that uses beds interchangeably for either acute or long-term care and shall approve the use of this method when a hospital can demonstrate that its use would contribute significantly to the more efficient or effective administration of this part and would be in the interest of program beneficiaries.".

(2) Section 1861(v)(1) is amended by adding at the end thereof the following new subparagraph:

"(G) Where a hospital furnishes inpatient services that would otherwise constitute post-hospital extended care services if furnished by a skilled nursing facility on the basis of a determination made by a Professional Standards Review Organization (or, in the absence of such a qualified organization, by such organization or agency with review responsibility as is otherwise provided for under this title) that (i) post-hospital extended care services are medically necessary; and (ii) such services are not otherwise available (as determined in accordance with criteria established by the Secretary) at the time the determination is made that post-hospital extended care services rather than inpatient hospital services are medically necessary (and for such period as the circumstances described in clauses (i) and (ii) continue to apply); and where the Secretary finds that such hospital (I) has had, during the immediately preceding calendar year, an average daily occupancy rate of less than 80 percent, and (II) could be granted a certificate of need for the provision of long-term care services from the designated State health planning and development agency for the State in which the hospital is located, the reasonable cost of such services for such hospital shall be computed as provided for in section 1882(a). Where payment is made in accordance with the preceding sentence, the individual who is furnished such services will be deemed to have received post-hospital extended care services in like manner and to the same extent as if the services furnished to him had been post-hospital extended care services furnished by a skilled nursing facility under an agreement under section 1866.".

(3) Within three years after the date of the enactment of this Act, the Secretary shall submit to the Congress a report evaluating the program established by the amendment made by paragraph (1) of this subsection and shall include in such report an analysis of—

(A) the extent and effect of the agreements under the program on availability and effective and economical provision of long-term care services, and

(B) whether the program should be continued.

(b) Title XIX of the Social Security Act is amended by adding after section 1913 (added by section 19(d) of this Act) the following new section:

"HOSPITAL PROVIDERS OF SKILLED NURSING AND INTERMEDIATE CARE SERVICES

"SEC. 1914. (a) Notwithstanding any other provision of this title, payment may be made, in accordance with this section, under a State plan approved under this title for skilled nursing facility services and intermediate care facility services furnished by a hospital which has in effect an agreement under section 1882.

"(b)(1) Payment to any such hospital, for any skilled nursing or intermediate care facility services furnished, shall be at a rate equal to the average rate per patient-day paid for routine services during the previous calendar year under this title to skilled nursing and intermediate care facilities located in the State in which the hospital is located. The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

"(2) With respect to any period for which a hospital has an agreement under section 1882, in order to allocate routine costs between hospital and long-term

care services, the total reimbursement for routine services received from all classes of long-term care patients (including title XVIII, title XIX, and private pay patients) shal be subtracted from the hospital total routine costs before calculations are made to determine title XIX reimbursement for routine hospital services.

"(c) The State plan may provide an alternative method for determining the amount of payment for long-term care services furnished in a distinct part of a hospital (where the conditions described in section 1882(g) are met) that is the same as the method prescribed in subsection (b) of this section for determining the amount of payment for such services furnished by a hospital that uses beds interchangeably for either acute or long-term care.".

(c) The amendments made by this section become effective on the date on which final regulations, promulgated by the Secretary to implement the amendments, are first issued; and those regulations shall be issued not later than the first day of the sixth calendar month following the month in which this Act is enacted.

COORDINATED AUDITS UNDER THE SOCIAL SECURITY ACT

SEC. 21. (a) Title XI of the Social Security Act is amended by inserting the following new section after the section added by section 17 of this Act:

"COORDINATED AUDITS

"SEC. 1128. (a) If an entity provides services reimbursable on a cost-related basis under title V or XIX, as well as services reimbursable on such a basis under title XVIII, the Secretary shall require, as a condition for payment to any State under title V or XIX with respect to administrative costs incurred in the performance of audits of the books, accounts, and records of that entity, that these audits be coordinated through common audit procedures with audits performed with respect to the entity for purposes of title XVIII. The Secretary shall specify by regulation such methods as he finds feasible and equitable for the apportionment of the cost of coordinated audits between the program established under title V or XIX and the program established under title XVIII. Where the Secretary finds that a State has declined to participate in such a common audit with respect to title V or XIX, he shall reduce the payments otherwise due such State under such title by an amount which he estimates to be in excess of the amount that would have been apportioned to the State under the title (for the expenses of the State incurred in the common audit) if it had participated in the common audit.

"(b)(1) In the case of entities which have audits coordinated under subsection (a), the Secretary shall establish one or more projects to demonstrate the feasibility of creating a single coordinated appeal hearing to adjudicate those administrative cost items which are determined under such a coordinated audit and which such entities dispute and appeal.

"(2) In the case of a demonstration project under this subsection, the Secretary may waive such requirements of title V, XVIII, or XIX as would prevent carrying out the project or would require duplicative activity or otherwise create unnecessary administrative burdens in carrying out the project.

"(3) The Secretary shall report to Congress not later than April 1, 1982, on demonstration projects conducted under this subsection, including the reaction of the entities involved and estimates of any savings effected through reduction of duplication of appeal hearings, and shall include in such report recommendations for such legislation as the Secretary deems appropriate to insure the maximum feasible coordination of such appeal hearings.

"(4) The Secretary shall also provide for the review of the feasibility of establishing a single coordinated process for the collection of overpayments established in a coordinated audit under subsection (a). The Secretary shall report to Congress not later than April 1, 1981, on such review and on such recommendations for changes in legislation as the Secretary deems appropriate.".

(b)(1) Section 1902(a) of such Act is amended—

(A) by striking out "and" at the end of paragraph (39);

(B) by striking out the period at the end of paragraph (40) and inserting in lieu thereof "; and"; and

(C) by inserting after paragraph (40) the following new paragraph:

"(41) provide (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be

audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that such audits, for such entities also providing services under title XVIII, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such part, and (C) for payment of such proportion of costs of each such common audit as is determined under methods specified by the Secretary under section 1128(a).".

(2)(A) The amendments made by paragraph (1) shall (except as provided under subparagraph (B)) apply to medical assistance provided, under a State plan approved under title XIX of the Social Security Act, on and after the first day of the first calendar quarter beginning more than 30 days after the date of enactment of this Act.

(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by paragraph (1), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act.

(c)(1) Section 505(a) of such Act is amended—

(A) by striking out "and" at the end of paragraph (14);

(B) by striking out the period at the end of paragraph (15) and inserting in lieu thereof "; and"; and

(C) by inserting after paragraph (15) the following new paragraph:

"(16) provides (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that such audits, for entities also providing services under title XVIII, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such part, and (C) for payment of such proportion of costs of each such common audit as is determined under methods specified by the Secretary under section 1128(a).".

(2) The amendments made by paragraph (1) shall apply to services provided, under a State plan approved under title V of the Social Security Act, on and after the first day of the first calendar quarter beginning more than 30 days after the date of enactment of this Act.

(d) The Secretary shall report to the Congress, not later than July 1, 1980, on actions the Secretary has taken (1) to coordinate the conduct of institutional audits and inspections which are required under the programs funded under title V, XVIII, or XIX of the Social Security Act, and (2) to coordinate such audits and inspections with those conducted by other cost payers, and he shall include in such report recommendations for such legislation as he deems appropriate to assure the maximum feasible coordination of such institutional audits and inspections.

VOLUNTARY CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES

SEC. 22. (a) Title XVIII of the Social Security Act is amended by adding after section 1882 (added by section 20(a)(1) of this Act) the following new section:

"VOLUNTARY CERTIFICATION OF MEDICARE SUPPPLEMENTAL HEALTH INSURANCE POLICIES

"SEC. 1883. (a) The Secretary shall establish a procedure whereby medicare supplemental policies (as defined in subsection (g)) may be certified by the Secretary as meeting minimum standards set forth in subsection (c). Such procedure shall provide an opportunity for any insurer to submit any such policy, and such additional data as the Secretary finds necessary, to the Secretary for his examination and for his certification thereof as meeting the standards set forth in subsection (c). Such certification shall remain in effect, if the insurer files a statement with the Secretary no later than December 31 of each year stating that the policy continues to meet the standard set forth in subsection (c), and if the insurer submits such additional data as the Secretary

finds necessary to independently verify the accuracy of such notarized statement. Where the Secretary determines such a policy meets (or continues to meet) the required standards, he shall authorize the insurer to have printed on such policy an emblem which the Secretary shall cause to be designed for use as an indication that a policy has received the Secretary's certification. The Secretary shall provide each State insurance commissioner with a list of all the policies which have received his certification.

"(b) Any medicare supplemental policy, including any such policy which is a mail order policy, issued in any State which has established under State law a regulatory program providing for the application of minimum standards with respect to such policies equal to or more stringent than the standards provided for under subsection (c) shall be deemed (for so long as the Secretary finds such State program continues to require compliance with such standards) to meet the standards set forth in subsection (c).

"(c) The Secretary shall not certify under this section any medicare supplemental policy for any period, nor continue a certification for any period, unless he finds that for such period such policy—

"(1) meets standards set forth by the Secretary with respect to adequacy of coverage (either in a single policy or, in the case of nonprofit hospital and medical service associations, in one or more policies issued in conjunction with one another), but such standards shall not require coverage in excess of coverage of the part A medicare deductible and the following coverage required under section 7(I)(2) of the 'NAIC Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act', adopted by the National Association of Insurance Commissioners on June 6, 1979:

"(A) coverage of part A medicare eligible expenses for hospitalization to the extent not covered under part A from the 61st day through the 90th day in any medicare benefit period;

"(B) coverage of part A medicare eligible expenses incurred as daily hospital charges during use of medicare's lifetime hospital inpatient reserve days;

"(C) upon exhaustion of all medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 90 percent of all medicare part A eligible expenses for hospitalization not covered by medicare, subject to a lifetime maximum benefit of an additional 365 days; and

"(D) coverage of 20 percent of the amount of medicare eligible expenses under part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket deductible of $200 of such expenses and to a maximum benefit of at least $5,000 per calendar year;

"(2) is written in simplified language, and in a form, which can be easily understood by purchasers;

"(3) does not limit or preclude liability under the policy for a period longer than 6 months because of a health condition existing before the policy is effective;

"(4) contains a prominently displayed 'no loss cancellation clause' enabling the insured to return the policy within 30 days of the date of receipt of the policy (or the certificate issued thereunder) with return in full of any premium paid;

"(5) can be expected (as estimated for such period, not to exceed one year, to the maximum extent appropriate, on the basis of actual claims experience and premiums for such policy and in accordance with accepted actuarial principles and practices) to return to policyholders in the form of aggregate benefits provided under the policy, at least such percentage of the aggregate amount of premiums collected as the Secretary finds reasonable (taking into account all relevant underwriting and other considerations relating to the design and marketing of such policies) for all group policies and, separately, for all individual policies; and

"(6) contains a written statement, in such form as the Secretary may prescribe, for prospective purchasers of such information as the Secretary shall prescribe relating to (A) the policy's premium, coverage in relation to the coverage and exclusions under medicare, and renewability provisions, and (B) the identification of the insurer and its agents.

"(d)(1) Whoever knowingly or willfully makes or causes to be made or induces or seeks to induce the making of any false statement or representation

of a material fact with respect to the compliance of any policy with the standards set forth in subsection (c) or in regulations promulgated pursuant to such subsection, or with respect to the use of the emblem designed pursuant to subsection (a), shall be fined not more than $25,000 or imprisoned not more than 5 years, or both.

"(2) Whoever falsely assumes or pretends to be acting, or misrepresents in any way that he is acting under the authority of or in association with, the program of health insurance established by this title, or any Federal agency, for the purpose of selling or attempting to sell insurance, or in such pretended character demands, or obtains money, paper, documents, or anything of value, and whoever knowingly permits another person to take such an action or make such a representation on his behalf, shall be fined not more than $25,000 or imprisoned not more than 5 years, or both.

"(3)(A) Whoever knowingly sells a health insurance policy to an individual entitled to benefits under part A or enrolled under part B of this title, with knowledge that such policy substantially duplicates health benefits to which such individual is otherwise entitled, other than benefits to which he is entitled under a requirement of State or Federal law (other than this title), shall be fined not more than $25,000 or imprisoned not more than 5 years, or both.

"(B) For purposes of this paragraph, benefits which are payable to or on behalf of an individual without regard to other health benefit coverage of such individual, shall not be considered as duplicative.

"(C) This paragraph shall not apply with respect to the selling of a group policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations.

"(4)(A) Whoever knowingly, directly or through his agent, mails or causes to be mailed any matter for a prohibited purpose (as determined under subparagraph (B)) shall be fined not more than $25,000 or imprisoned not more than 5 years, or both.

"(B) For purposes of subparagraph (A), a prohibited purpose means the advertising, solicitation, or offer for sale of a medicare supplemental policy (or a certificate issued thereunder), or the delivery of such a policy (or a certificate issued thereunder), into any State in which such policy or certificate has not been approved by the State commissioner or superintendent of insurance. For purposes of this subparagraph any medicare supplemental policy (or a certificate issued thereunder) shall be deemed to be approved by the State commissioner or superintendent of insurance of such State if (i) it has been approved by the Secretary or by the commissioners or superintendents of insurance in the States in which more than 30 percent of such policies or certificates are sold, or (ii) such State has in effect a law which the commissioner or superintendent of insurance has determined gives him the authority to review, and to approve, or effectively bar from sale in the State, such policy or certificate; except that such a policy or certificate shall not be deemed to be approped by a State commissioner or superintendent of insurance if such State requests to the Secretary that such policy or certificate be subject to such State's approval.

"(C) This paragraph shall not apply in the case of a person who mails or causes to be mailed a medicare supplemental policy (or certificate issued thereunder) into a State if such person has ascertained that the party insured under such policy to whom (or on whose behalf) such policy or certificate is mailed is located in such State on a temporary basis.

"(D) This paragraph shall not apply in the case of a person who mails or causes to be mailed a duplicate copy of a medicare supplemental policy (or of a certificate issued thereunder) previously issued to the party to whom (or on whose behalf) such duplicate copy is mailed, if such policy or certificate expires not more than 12 months after the date on which the duplicate copy is mailed.

"(E) The Secretary shall provide to all individuals entitled to benefits under this title (and to the extent feasible, individuals about to become so entitled) such information as will permit such individuals to evaluate the value of medicare supplemental policies to them and the relationship of any such policies to benefits provided under this title.

"(f)(1)(A) The Secretary shall, in consultation with Federal and State regulatory agencies, the National Association of Insurance Commissioners, private

insurers, and organizations representing consumers and the aged, conduct a comprehensive study and evaluation of the comparative effectiveness of various State approaches to the regulation of medicare supplemental policies in (i) limiting marketing and agent abuse, (ii) assuring the dissemination of such information to individuals entitled to benefits under this title (and to other consumers) as is necessary to permit informed choice, (iii) promoting policies which provide reasonable economic benefits for such individuals, (iv) reducing the purchase of unnecessary duplicative coverage, (v) improving price competition, and (vi) establishing effective State programs as described in subsection (b).

"(B) Such study shall also address the need for standards or certification of health insurance policies sold to individuals eligible for benefits under this title, other than medicare supplemental policies.

"(C) The Secretary shall, no later than July 1, 1981, submit a report to the Congress on the results of such study and evaluation, accompanied by such recommendations as the Secretary finds warranted by such results with respect to the need for legislative or administrative changes to accomplish the objectives set forth in subparagraphs (A) and (B), including the need for a mandatory Federal regulatory program to assure the marketing of appropriate types of medicare supplemental policies, and such other means as he finds may be appropriate to enhance effective State regulation of such policies.

"(2) The Secretary shall submit to the Congress on January 1, 1982, and periodically as may be appropriate thereafter (but not less often than once every 2 years), a report evaluating the effectiveness of the certification procedure and the criminal penalties established under this section, and shall include in such reports an analysis of—

"(A) the impact of such procedure and penalties on the types, market share, value, and cost to individuals entitled to benefits under this title of medicare supplemental policies which have been certified by the Secretary;

"(B) the need for any changes in the certification procedure to improve its administration or effectiveness; and

"(C) whether the certification program and criminal penalties should be continued.

"(g) For purposes of this section, a medicare supplemental policy is a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this title, which provides reimbursement for expenses incurred for services and items for which payment may be made under this title but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed pursuant to this title; but does not include any such policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations.

"(h) The Secretary shall prescribe such regulations as may be necessary for the effective, efficient, and equitable administration of the certification procedure established under this section.".

(b) The amendment made by this section shall become effective on the date of the enactment of this Act, except that the provisions of paragraph (4) of section 1883(d) of the Social Security Act (as added by this section) shall become effective on January 1, 1982.

(c) The Secretary of Health and Human Services shall issue final regulations to implement the certification procedure established under section 1883(a) of the Social Security Act not later than October 1, 1980. No policy shall be certified and no policy may be issued bearing the emblem authorized by the Secretary under such section, until January 1, 1982. On and after January 1, 1982, policies certified by the Secretary may bear such emblem, including policies which were issued prior to January 1, 1982, and were subsequently certified, and insurers may notify holders of such certified policies issued prior to January 1, 1982, using such emblem in the notification.

DEMONSTRATION PROJECTS RELATING TO THE TRAINING OF AID TO FAMILIES WITH DEPENDENT CHILDREN RECIPIENTS AS HOME HEALTH AIDES

SEC. 23. (a) The Secretary of Health, Education, and Welfare (hereinafter in this section referred to as the "Secretary") may enter into agreements with

States, selected at his discretion, for the purpose of conducting demonstration projects for the training and employment of eligible participants as homemakers or home health aides, who shall provide authorizd services to elderly or disabled individuals, or other individuals in need of such services, to whom such services are not otherwise reasonably and actually available or provided, and who would, without the availability of such services, be reasonably anticipated to require institutional care.

(b) For purposes of this section the term "eligible participant" means an individual who has voluntarily applied for participation and who, at the time such individual enters the project established under this section, has been certified by the appropriate agency of State or local government as being eligible for financial assistance under a State plan approved under part A of title IV of the Social Security Act and as having continuously received such financial assistance during the ninety-day period which immediately precedes the date on which such individual enters such project and who, within such ninety-day period, had not been employed as a homemaker or home health aide.

(c) (1) The Secretary shall enter into agreements under this section with no more than twelve States. Priority shall be given to States which have demonstrated interest in providing services of the type authorized under this section.

(2) State may apply to enter into an agreement under this section in such manner and at such time as the Secretary may prescribe.

(3) Any State entering into an agreement with the Secretary under this section must—

(A) provide that the demonstration project shall be administered by a State health services agency designated for this purpose by the Governor (which may be the State agency administering or responsible for the administration of the State plan for medical assistance under title XIX of the Social Security Act) ;

(B) provide that the agency designated pursuant to subparagraph (A) shall, to the maximum extent feasible, arrange for coordinating its activities under the agreement with activities of other State agencies having related responsibilities ;

(C) establish a formal training program, which meets such standards as the Secretary may establish to assure the adequacy of such program, to prepare eligible participants to provide part-time and intermittent homemaker services or home health aide services to individuals who are elderly, disabled, or otherwise in need of such services ;

(D) provide for the full-time employment of those eligible participants who successfully complete the training program with one or more public agencies (or, by contract, with private bona fide nonprofit agencies) as homemakers or home health aides, rendering authorized services, under the supervision of persons determined by the State to be qualified to supervise the performance of such services, to individuals described in subsection (a) at wage levels comparable to the prevailing wage levels in the area for similar work ;

(E) provide that such services provided under subparagraph (D) shall be made available without regard to income of the individual requiring such services, but that a reasonable fee will be charged (on a sliding scale basis) for such services provided to individuals who have income in excess of 200 percent of the needs standard in such State under the State plan approved under part A of title IV of the Social Security Act for a household of the same size as such individual's household ;

(F) provide for a system of continuing independent professional review by an appropriate panel, which is not affiliated with the entity providing the services involved, to assure that services are not provided only to individuals reasonably determined to be in need of such supportive services ;

(G) provide for evaluation of the project and review of all agencies providing services under the project ;

(H) submit periodic reports to the Secretary as he may require ; and

(I) meet such other requirements as the Secretary may establish for the proper and efficient implementation of the project.

(4) The number of participants in any project shall not exceed that number which the Secretary determines to be reasonable, based upon the capability of the agencies involved to train, employ, and properly utilize eligible partici-

pants. Such number may be appropriately modified, subsequently, with the approval of the Secretary.

(5) Any contract with a private bona fide nonprofit agency entered into pursuant to paragraph (3)(D) shall provide for reasonable reimbursement of such agencies for services on a basis proportionate to the amount of time allocated to individuals eligible to receive such services under this section (and, in case such agency is an institution, the amount of the reimbursement shall not exceed the amount of reimbursement which would have been payable if the services involved had been provided by a free-standing agency.

(6) For purposes of this section, a facility of the Veterans' Administration shall, at the request of the Administrator of Veterans' Affairs, be considered to be a public agency. In the case of any such facility which is so considered to be a public agency, of the costs determined under this section which are attributable to such facility, 90 percent shall be paid by the State and 10 percent by the Veterans' Administration.

(d)(1) For purposes of this section, authorized homemaker and home health aide services include part-time or intermittent—

(A) personal care, such as bathing, grooming, and toilet care;
(B) assisting patients having limited mobility;
(C) feeding and diet assistance;
(D) home management, housekeeping, and shopping;
(E) health-oriented recordkeeping;
(F) family planning services; and
(G) simple procedures for identifying potential health problems.

(2) Such authorized services do not include any services performed in an institution, or any services provided under circumstances where institutionalization would be substantially more efficient as a means of providing such services.

(e)(1) Agreements shall be entered into under this section between the Secretary and the State agency designated by the Governor. Under such agreement the Secretary shall pay to the State, as an additional payment under section 1903 of such Act for each quarter, an amount equal to 90 percent of the reasonable costs incurred (less the Federal share of any related fees collected) by such State during such quarter in carrying out a demonstration project under this section, including reasonable wages and other employment costs of eligible participants employed full time under such project (and, for purposes of determining the amount of such additional payment, the 10 percent referred to in subsection (c)(6), paid by the Veterans' Administration, shall be deemed to be a cost incurred by the State in carrying out such a project).

(2) Demonstration projects under this section shall be of a maximum duration of four years, plus an additional time period of up to six months for planning and development, and up to six months for final evaluation and reporting. Federal funding under this subsection shall not be available for the employment of any eligible participant under the project after such participant has been employed for a period of three years.

(f) For purposes of title IV of the Social Security Act, any eligible participant taking part in a training program under a project authorized under this section shall be deemed to be participating in a work incentive program established by part C of such title.

(g) For the first year (and such additional immediately succeeding period as the State may specify) during which an eligible participant is employed under the project established under this section, such participant shall, notwithstanding any other provision of law, retain any eligibility for medical assistance under a State plan approved under title XIX of the Social Security Act, and any eligibility for social and supportive services provided under the State plan approved under part A of title IV of such Act, which such participant had at the time such participant entered the training program established under this section.

(h) The Secetary shall submit annual reports to the Congress evaluating the demonstration projects carried out under this section, and shall submit a final report to the Congress not more than six months after he has received the final reports from all States participating in such projects.

(i) The Secretary shall, and is hereby authorized to, waive such requirements, including formal solicitation and approval requirements, as will further expeditious and effective implementation of this section.

REIMBURSEMENT FOR HEALTH MAINTENANCE ORGANIZATIONS

SEC. 24. (a) Section 1876 of the Social Security Act is amended to read as follows:

"PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

"SEC. 1876. (a)(1) The Secretary shall annually determine a per capita rate of payment—

"(A) for each class of individuals who are enrolled (in accordance with this section) with a health maintenance organization which has entered into a contract under this section and who are entitled to benefits under part A and enrolled under part B; and

"(B) for each class of individuals who are so enrolled with such an organization and who are enrolled under part B only.

Such rate for each class shall be equal to 95 percent of the adjusted average per capita cost for that class.

"(2) For purposes of this section, the term 'adjusted average per capita cost' means the average per capita amount that the Secretary estimates in advance (on the basis of actual experience, or retrospective actuarial equivalent based upon an adequate sample and other information and data, in a geographic area served by a health maintenance organization or in a similar area, with appropriate adjustments to assure actuarial equivalence) would be payable in any contract year for services covered under parts A and B, or part B only, and types of expenses otherwise reimbursable under parts A and B, or part B only (including administrative costs incurred by organizations described in section 1816 and 1842), if the services were to be furnished by other than a health maintenance organization or, in the case of services covered only under section 1861(s)(2)(G), if the services were to be furnished by a physician or as an incident to a physician's service.

"(3) In establishing classes of individuals for purposes of this subsection, the Secretary shall take into consideration such factors as age, sex, institutional status, disability status, and place of residence.

"(4) After determining under paragraph (1) the rate of payment to be utilized with respect to a health maintenance organization, the Secretary shall make monthly payments, in advance and in accordance with such rate, except as provided in subsection (i)(2), to such organization for each individual enrolled in accordance with this section with the organization. Such payments shall be in lieu of payments which (in the absence of the contract entered into under this section) would be payable otherwise pursuant to section 1814(b) or 1833(a) for services furnished by or through the organization to individuals enrolled with the organization and entitled to benefits under part A and enrolled under part B or enrolled under part B only.

"(5) The payment to a health maintenance organization under this subsection for individuals enrolled in accordance with this section with the organization and entitled to benefits under part A and enrolled under part B shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The portion of that payment to the organization for a month to be paid by the latter trust fund shall be equal to 200 percent of the sum of—

"(A) the product of (i) the number of such individuals for the month who have attained age 65, and (ii) the monthly actuarial rate for supplementary medical insurance for the month as determined under section 1839(c)(1); and

"(B) the product of (i) the number of such individuals for the month who have not attained age 65, and (ii) the monthly actuarial rate for supplementary medical insurance for the month as determined under section 1839(c)(4).

The remainder of that payment shall be paid by the former trust fund.

"(b)(1) For purposes of this section, the term 'health maintenance organization' means a public or private organization, organized under the laws of any State, which is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) or which—

"(A) provides or otherwise makes available to enrolled participants health care services, including at least the following health care services:

physicians' services performed by physicians (as defined in section 1861(r)(1)), inpatient hospital services, laboratory, X-ray, emergency, and preventive services, and out of area coverage;

"(B) is compensated (except for deductibles, coinsurance, and copayments) for the provision of health care services to enrolled participants by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health care service actually provided;

"(C) provides physicians' services primarily (i) directly through physicians who are either employees or partners of such organization, or (ii) through arrangements with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis);

"(D) assumes full financial risk on a prospective basis for the provision of the health care services listed in subparagraph (A), except that a health maintenance organization may obtain insurance or make other arrangements—

"(i) for the cost of providing to any enrolled participant health care services listed in subparagraph (A) the aggregate value of which exceeds $5,000 in any year,

"(ii) for the cost of health care services listed in subparagraph (A) provided to its enrolled participants other than through the organization because medical necessity required their provision before they could be secured through the organization, and

"(iii) for not more than 90 percent of the amount by which it costs for any of its fiscal years exceed 115 percent of its income for such fiscal year; and

"(E) has made adequate provision against the risk of insolvency, which provision is satisfactory to the Secretary.

"(2) The Secretary may not enter into a contract with a health maintenance organization under this section, unless, with respect to individuals enrolled with the organization under this section, the following requirements are met:

"(A) BENEFIT PACKAGE.—The organization must provide to such individuals who are—

"(i) entitled to benefits under part A and enrolled under part B, only those services covered under parts A and B of this title, or

"(ii) only enrolled under part B, only those services covered under such part,

except that, in addition, the organization may provide such individuals with such additional health care services either as the Secretary may approve or as such individuals may elect, at their option, to have covered. The Secretary shall approve any such additional health care services which the organization proposes to offer to such individuals, unless the Secretary determines that including such additional services will substantially discourage enrollment by covered individuals with the organization.

"(B) LIMITS ON DEDUCTIBLES, COINSURANCE, AND COPAYMENTS.—The amount of any deductibles, coinsurance, and copayments required by such individuals will not exceed the limits applicable under subsection (g) of this section.

"(C) PROVIDERS.—The organization must provide the services described in subparagraph (A) to such individuals through institutions, entities, and persons meeting the applicable requirements of section 1861.

"(D) OPEN ENROLLMENT.—The organization must have an open enrollment period, for the enrollment of such individuals, of reasonable duration at least every year during which it accepts up to the limits of its capacity and without restrictions, except as may be authorized in regulations, individuals who are eligible to enroll under subsection (d) in the order in which they apply for enrollment, unless to do so would result in failure to meet the requirements of subsection (h) or would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the population in the geographic area served by the organization.

"(E) EXPULSION OF MEMBERS.—The organization must (i) provide assurances to the Secretary that it will not expel or refuse to re-enroll any such individual because of the individual's health status or requirements for health care services, and (ii) notify each such individual of such fact at the time of the individual's enrollment.

"(F) AVAILABILITY OF SERVICES.—The organization must—

"(i) make the services described in subparagraph (A) (and such other health care services as such individuals have contracted for) (I) available and accessible to each individual, within the area served by the organization, promptly as appropriate and in a manner which assures continuity, and (II) when medically necessary, available and accessible twenty-four hours a day and seven days a week, and

"(ii) provide for reimbursement with respect to services which are described in clause (i) and which are provided to such an individual other than through the organization, if the services were medically necessary and immediattly required because of an unforseen illness, injury, or condition.

"(G) GRIEVANCE PROCEDURES.—The organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and such individuals.

"(H) QUALITY ASSURANCE.—The organzation must have arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for health care services it provides to such individuals, which program (i) stresses health outcomes and (ii) provides review by physicians and other health care professionals of the process followed in the provisions of such health care services.

"(c) If an individual is enrolled in accordance with this section with a health maintenance organization, only the health maintenance organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.

"(d) Subject to the provisions of subsection (e), every individual entitled to benefits under part A and enrolled under part B or enrolled under part B only (other than an individual medically determined to have end-stage renal disease) shall be eligible to enroll under this section with any health maintenance organization with which the Secretary has entered into a contract under this section and which serves the geographic area in which the individual resides.

"(e)(1) An individual may enroll under this section with a health maintenance organization as may be prescribed in regulations and may terminate his enrollment with the health maintenance organization as of the bginning of the first calendar month following a full calendar month after the request is made for such termination.

"(2) The Secretary may prescribe the procedures and conditions under which a health maintenance organization that has entered into a contract with the Secretary under this subsection may inform individuals eligible to enroll under this section with the organization about the organizaton, or may enroll such individuals with the organization.

"(f) Any individual enrolled with a health maintenance organizaton under this section who is dissatisfied by reason of his failure to receive any health care service to which he believes he is entitled and at no greater charge than he believes he is required to pay shall, if the amount in controversy is $100 or more, be entitled to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the health maintenance organization a party. If the amount in controversy is $1,000 or more, the individual or health maintenance organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the health maintenance organization sholl be entitled to be parties to that judicial review.

"(g)(1) In no case may—

"(A) the portion of a health maintenance organization's premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (with respect to services covered under parts A and B) to individuals who are enrolled in accordance with this section wth the organization and who are entitled to benefits under part A and enrolled under part B, or

"(B) the portion of its premium rate and actuarial value of its deductibles, coinsurance, and copayments charged (with respect to services covered under part B) to individuals who are enrolled in accordance with this section with the organization and enrolled under part B only exceed the actuarial value of the coinsurance and deductibles that would be applicable on the average to individuals enrolled in accordance with this sec-

tion with the organization (or, if the Secretary finds that adequate data are not available to determine that actuarial value, other appropriate data) and entitled to benefits under part A and enrolled under part B, or enrolled under part B only, respectively, if they were not members of a health maintenance organization.

"(2) If the health maintenance organization provides to its enrollee under this section services in addition to services covered under parts A and B of this title, election of coverage for such additional services (unless such services have been approved by the Secretary under subsection (b)(2)(A)) shall be optional for such enrollees and such organization shall furnish such enrollees with information of the portion of its premium rate or other charges applicable to such additional services. In no case may the sum of—

"(A) the portion of such organization's premium rate charged, with respect to such additional services, to individuals enrolled in accordance with this section, and

"(B) the actuarial value of its deductibles, coinsurance, and copayments charged, with respect to such services, to such individuals

exceed the adjusted community rate for such services.

"(3) For purposes of this section, the term 'adjusted community rate' for a service means, at the election of a health maintenance organization, either—

"(A) the rate of payment for that service which the Secretary annually estimates would apply to an individual enrolled in accordance with this section with the health maintenance organization if the rate of payment were determined under a 'community rating system' (as defined in section 1302(8) of the Public Health Service Act, other than subparagraph (C)), or

"(B) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to an individual enrolled in accordance with this section with the health maintenance organization, as the Secretary annually estimates is attributable to that service,

but adjusted for differences between the utilization characteristics of the individuals enrolled with the health maintenance organization under this section and the utilization characteristics of the other members of the organization (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of individuals in other health maintenance organizations, or individuals in the area, in the State, or in the United States, eligible to enroll under this section with a health maintenance organization and the utilization characteristics of the rest of the population in the area, in the State, or in thet United States, respectively).

"(4) Notwithstanding any other provision of law, the health maintenance organization may (in the case of the provision of services to an individual enrolled in accordance with this section for an illness or injury for which the member is entitled to benefits under a workman's compensation law or under an automobile insurance policy) charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law or policy—

"(A) the insurance carrier, employer, or other entity which under such law or policy is to pay for the provision of such services, or

"(B) such member to the extent that such member has been paid under such law or policy for such services.

"(h)(1) Except as provided in paragraph (2), each health maintenance organization with which the Secretary enters into a contract under this section shall have, for the duration of such contract, an enrolled membership at least half of which consists of individuals who are not entitled to benefits under this title or under a State plan approved under title XIX.

"(2) The Secretary may modify or waive the requirement described in paragraph (1) in circumstances which, as determined by the Secretary, warrant special consideration (and may take into account, in determining whether to modify or waive that requirement, the reasonableness of the organization's premium rate and other charges for members entitled to benefits under this title or under a State plan approved under title XIX); except that the Secretary may make such a modification or waiver only on the condition that the health maintenance organization will not have, for the duration of such contract, an enrolled membership of which one-half or more are individuals entitled to benefits under part A or enrolled under part B.

"(i)(1) The Secretary may enter into a contract with any health maintenance organization, as defined in subsection (b)(1), for the purpose of carrying out this section.

"(2) Each contract shall provide that—

"(A) if the adjusted community rate, as defined in subsection (g)(3), for services covered under parts A and B (as reduced for the actuarial value of the coinsurance and deductibles under those parts) for individuals enrolled in accordance with this section with the organization and entitled to benefits under part A and enrolled in part B, or

"(B) if such adjusted community rate for services under part B (as reduced for the actuarial value of the coinsurance and deductibles under that part) for individuals enrolled in accordance with this section with the organization and enrolled under part B only

is less than the average of the per capita rates of payment to be made under subsection (a)(1) at the beginning of an annual contract period for individuals enrolled in accordance with this section with the organization and entitled to benefits under part A and enrolled in part B, or enrolled in part B only, respectively, the health maintenance organization shall provide to each individual enrolled in accordance with this section with the organization and entitled to benefits under part A and enrolled in part B, or enrolled in part B, respectively, additional benefits which are selected by the health maintenance organization and which the Secretary finds are at least equal in value to the difference between the average per capita payment and the adjusted community rate (as so reduced); except that this paragraph shall not apply with respect to any organization which elects to receive a lesser payment to the extent that there is no longer a difference beween the average per capita payment and adjusted community rate (as so reduced). If the Secretary finds that there is insufficient enrollment experience to determine an average of the per capita rates of payment to be made under subsection (a)(1) at the beginning of a contract period, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this section.

"(3) Such additional benefits shall be (A) the reduction of the premium rate or other charges made with respect to services furnished by the organization to individuals enrolled under this section, or (B) the provision of additional health benefits, or both.

"(4) The effective date of any contract executed pursuant to this subsection shall be specified in the contract.

"(5) Each contract under this section—

"(A) shall provide that the Secretary, or any person or organization designated by him—

"(i) shall have right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the contract, and

"(ii) shall have right to audit and inspect any books and records of the health maintenance organization that pertain (I) to the ability of the organization to bear the risk of potential financial losses, and (II) to services performed or determinations of amounts payable under the contract;

"(B) shall require the organization to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this title, to each individual enrolled under this section with the organization; and

"(C) shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary.

"(6) The Secretary may not enter into contract with a health maintenance organization under this section if a former contract with that organization under this section was terminated at the request of the organization within the preceding five-year period, except in circumstances which warrant special consideration, as determined by the Secretary.

"(7) The authority vested in the Secretary by this subsection may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.".

(b) Section 1861(s)(2) of such Act is amended—

(1) by striking out "and" in subparagraph (E);

(2) by inserting "and" after the semicolon in subparagraph (F); and

(3) by adding after subparagraph (F) the following new subparagraph:

"(G) services furnished pursuant to a contract under section 1876 to a member of a health maintenance organization by a physician assistant or by a nurse practitioner and such services and supplies furnished as an incident to his service to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service;".

(c) (1) Section 1861(aa) of such Act is amended—

(A) by striking out ", for purposes of paragraphs (1) and (2)," in paragraph (3);

(B) by redesignating paragraph (3) as subsection (bb) of section 1861; and

(C) by inserting the following subsection heading after and below paragraph (2):

"PHYSICIAN ASSISTANT AND NURSE PRACTITIONER"

(2) Section 3(e) of Public Law 95–210 is amended by striking out "section 1861 (aa) (3)" and inserting in lieu thereof "section 1861(bb)".

(d) (1) Section 1122 of the Social Security Act is amended by adding at the end the following new subsection:

"(j) A capital expenditure made by or on behalf of a health care facility shall not be subject to review pursuant to this section if the obligation of the capital expenditure by the facility would not be required to be reviewed under section 1527 of the Public Health Service Act.".

(2) Section 1124(a)(2)(A) of such Act is ameded by striking out "(as defined in section 1301(a) of the Public Health Service Act".

(e) The amendments made by this section (other than subsections (c) and (d)) shall apply with respect to services furinshed on or after the first day of the thirteenth calendar month which begins after the date of enactment of this Act, or earlier with respect to any health maintenace organization if the organization so requests and the Secretary of Health, Education, and Welfare agrees, except that such amendments shall not apply—

(1) with respect to services furnished by a health maintenance organization to any individual who is enrolled with that organization and entitled to benefits under part A, or enrolled in part B, of title XVIII of the Social Security Act at the time the organization first enters into a contract subject to the amendments made by this section, unless—

(A) the individual requests at any time that the amendments apply, or

(B) the Secretary determines at any time that the amendments should apply to all members of the health maintenance organization because of administrative costs or other administrative burdens involved and so informs in advance each affected member of the health maintenance organization, or

(2) with respect to services furnished by a health maintenace organization during the five-year period beginning with the date of enactment of this Act, if a contract between the organization and the Secretary of Health, Education, and Welfare under section 1876(i)(2)(A) of the Social Security Act was in effect immediately before the date of the enactment of this Act, unless the organization requests that the amendments apply earlier.

(f) The Secretary shall conduct a study of the additional benefits selected by health maintenace organizations pursuant to section 1876(i)(2) of the Social Security Act, as added by subsection (a) of this section. This Secretary shall report to the Congress within 24 months of the date of the enactment of this Act with respect to the findings and conclusions made as a result of such study.

(g) The Secretary shall conduct a study evaluating the extent of, and reasons for, the termination by medicare beneficiaries of their memberships in health maintenance organizations. In conducting such study the Secretary shall place special emphasis on the quantity and quality of medical care provided in health maintenance organizations and the quality of such care when provided on a fee-for-service basis. The Secretary shall submit an interim report to the Congress, within 2 years from the date of the enactment of this Act, and a final report within 5 years from such date containing the interim and final, respectively, findings and conclusions made as a result of such study.

QUALITY ASSURANCE PROGRAMS FOR CLINICAL LABORATORIES

SEC. 25. (a) Title XI of the Social Security Act is amended—

(1) by striking out "1977" in section 1123(a) and inserting in lieu thereof "1980", and

(2) by inserting the following new section after section 1128 (added by section 21 of this Act):

"QUALITY ASSURANCE PROGRAMS FOR CLINICAL LABORATORIES

"SEC. 1129. In exercising the authority provided under sections 1861(e) and 1861(s) of this Act for assuring the quality of diagnostic tests performed in hospitals and independent laboratories, the Secretary shall—

"(1) only impose such requirements, in addition to those provided for by state or local law, as are found by the Secretary to be necessary to correct deficiencies in the quality of particular types of tests or laboratories;

"(2) employ quality assurance methods designed to result in—

"(A) the least imposition of costs, and

"(B) the fewest restrictions on the personnel who may perform or supervise such tests,

consistent with adequate standards of quality assurance; and

"(3) to the extent feasible, employ quality assurance methods which take into account and are appropriate to the different types of laboratories to which they apply.".

(b) The amendment made by subsection (a) shall not be construed to require the Secretary of Health, Education, and Welfare to modify or repeal any regulations in effect on January 1, 1980.

REIMBURSEMENT OF CLINICAL LABORATORIES UNDER MEDICARE AND MEDICAID

SEC. 26. (a)(1) Section 1842 of the Social Security Act is amended by inserting at the end the following new subsection:

"(h) If a physician's bill or request for payment for a physician's services includes a charge to a patient for a laboratory test for which payment may be made under this part, the amount payable with respect to the test shall be determined as follows:

"(1) If the bill or request for payment indicates that the physician who submitted the bill or for whose services the request for payment was made personally performed or supervised the performance of the test or that another physician with whom the physician shares his practice personally performed or supervised the test, the payment shall be the reasonable charge for the test (less the applicable deductible and coinsurance amounts).

"(2) If the bill or request for payment indicates that the test was performed by a laboratory, identifies the laboratory, and indicates the amount the laboratory charged the physician who submitted the bill or for whose services the request for payment was made, payment for the test shall be the lower of—

"(A) the laboratory's reasonable charge to individuals enrolled under this part for the test, or

"(B) the amount the laboratory charged the physician for the test, plus a nominal fee (where the physician bills for such a service) to cover the physician's costs in collecting and handling the sample on which the test was performed (less the applicable deductible and coinsurance amounts).

"(3) If the bill or request for payment (A) does not indicate who performed the test, or (B) indicates that the test was performed by a laboratory but does not identify the laboratory or include the amount charged by the laboratory, payment shall be the lowest charged at which the carrier estimates the test could have been secured by a physician from a laboratory serving the locality (less the applicable deductible and coinsurance amounts).".

(2) The amendment made by paragraph (1) shall apply to bills submitted and requests for payment made on or after such date (not later than July 1, 1980) as the Secretary of Health, Education, and Welfare (hereinafter in this Act referred to as the "Secretary") prescribes by a notice published in the Federal Register.

(3) Not later than 24 months after the effective date specified in paragraph (2), the Secretary shall report to the Congress—

(A) the proportion of bills and requests for payment submitted (during the 18-month period beginning on such effective date) under title XVIII of the Social Security Act for laboratory tests which did not identify who performed the tests,

(B) the proportion of bills and requests for payment submitted during such period for laboratory tests with respect to which the amount paid under such title was less than the amount that would otherwise have been payable in the absence of section 1842(h) of such Act,

(C) with respect to requests for payment described in subparagraph (B) which were submitted by patients, the average additional cost per laboratory test to patients resulting from reductions in payment that would otherwise have been made for such tests in the absence of such section 1842(h), and

(D) with respect to bills described in subparagraph (B) which were submitted by physicians, the average reduction in payment per laboratory test to physicians resulting from the application of such section 1842(h).

(b)(1) Section 1902(a) of such Act, as amended by section 21 of this Act, is further amended (A) by striking out "and" at the end of paragraph (40), (B) by striking out the period at the end of paragraph (41) and inserting in lieu thereof "; and", and (c) by adding after paragraph (41) the following new paragraph:

"(42) if the State plan makes provision for payment to a physician for laboratory services the performance of which such physician (or any other physician with whom he shares his practice) did not personally perform or supervise, include provision to insure that payment under the State plan for such laboratory services not exceed the payment authorized for such services by section 1842(h).".

(2)(A) The amendments made by paragraph (1) shall (except as otherwise provided in subparagraph (B)) apply to medical assistance provided, under a State plan approved under title XIX of the Social Security Act, on and after the first day of the first calendar quarter that begins more than six months after the date of enactment of this Act.

(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by paragraph (1), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act.

(c)(1)(A) Section 1902(a)(23) of such Act is amended by inserting "(A)" before "has entered into" and by inserting before the semicolon at the end the following: ", or (B) during the three-year period beginning on the date of enactment of this clause, has made arrangements through a competitive bidding process or otherwise for the purchase of laboratory services referred to in section 1905(a)(3), if the Secretary has found that (i) adequate services will be available under such arrangements, (ii) such laboratory services will be provided only through laboratories (I) which meet the requirements of the section 1861(e)(9) or paragraphs (10) and (11) of section 1861(s), and such additional requirements as the Secretary may require, (II) no more than 75 percent of whose charges for such services are for services provided to individauls who are entitled to benefits under this title or under part A or part B of title XVIII, and (iii) charges for services provided under such arrangements are made at the lowest rate charged (determined without regard to administrative costs which are related solely to the method of reimbursement for such services) for comparable services by the provider of such services, or, if charged for on a unit price basis, such charges result in aggregate expenditures not in excess of expenditures that would be made if charges were at the lowest rate charged for comparable services by the provider of such services".

(B) The Secretary shall evaluate arrangements made for the purchase of laboratory services under section 1902(a)(23)(B) of the Social Security Act and shall transmit that evaluation to the Congress, together with recommen-

dations as to whether such section 1902(a)(23)(B) should be extended or modified, no later than 24 months after the date of enactment of this Act.

(2) Section 1902(a)(9) of such Act is amended—

(A) by striking out "and" at the end of subparagraph (A),

(B) by striking out the semicolon at the end of subparagraph (B) and inserting in lieu thereof ", and", and

(C) by adding after subparagraph (B) the following new subparagraph:

"(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the requirements of section 1861(e)(9) or paragraphs (10) and (11) of section 1861(s);".

REIMBURSEMENT OF PHYSICIANS' SERVICES IN TEACHING HOSPITALS

SEC. 27. (a)(1) Paragraph (7) of section 1861(b) of the Social Security Act is amended to read as follows:

"(7) a physician where the hopsital has a teaching program approved as specified in paragraph (6), if (A) the hospital elects to receive any payment due under this title for reasonable costs of such services, and (B) all physicians in such hospital agree not to bill charges for professional services rendered in such hospital to individuals covered under the insurance program established by this title.".

(2) Section 1832(a)(2)(B)(i)(II) of such Act is amended by striking out ", unless either clause (A) or (B) of paragraph (7) of such section is met" and inserting in lieu thereof "where the conditions specified in paragraph (7) of such section are met".

(b) The amendments made by this section shall apply with respect to cost accounting periods beginning on or after October 1, 1978, A hospital's election undersection 1861(b)(7)(A) of the Social Security Act (as administrered in accordance with section 15 of Public Law 93-233) as of September 30, 1978, shall constitute such hospital's election under such section (as amended by this Act) on and after October 1, 1978, until otherwise provided by the hospital.

REIMBURSEMENT OF MEDICAID FOR SERVICES FURNISHED BY NURSE-MIDWIVES

SEC. 28. (a)(1) Subsection (a) of section 1905 of the Social Security Act is amended—

(A) by striking out "and" at the end of paragraph (16);

(B) by redesignating paragraph (17) as paragraph (18); and

(C) by inserting after paragraph (16) the following new paragraph:

"(17) services furnished by a nurse-midwife (as defined in subsection (m)) which he is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not he is under supervision of, or associated with, a physician or other health care provider; and".

(2) Such section is further amended by adding at the end thereof the following new subsection:

"(m) The term 'nurse-midwife' means a registered nurse who has successfully completed a program of study and clinical experience meeting guidelines prescribed by the Secretary, or has been certified by an organization recognized by the Secretary, and performs services in the area of management of the care of mothers and babies (throughout the maternity cycle) which he is legally authorized to perform in the State in which he performs such services.".

(b) Section 1902(a) of such Act is amended—

(1) by striking out "clauses (1) through (5)" in paragraph (13)(B) and inserting in lieu thereof "paragraphs (1) through (5) and (17)";

(2) by striking out "clauses (1) through (5)" in paragraph (13)(C)(i) and inserting in lieu thereof "paragraphs (1) through (5) and (17)";

(3) by striking out "clauses numbered (1) through (16)" in paragraph (13)(C)(ii) and inserting in lieu thereof "paragraphs numbered (1) through (17)"; and

(4) by striking out "clauses (1) through (5) and (7)" in pararaph (14)(A)(i) and inserting in lieu thereof "paragraphs (1) through (5), (7), and (17)".

(c)(1) The amendments made by this section shall (except as provided under paragraph (2)) be effective with respect to payments under title XIX of the

Social Security Act for calendar quarters beginning more than one hundred and twenty days after the date of the enactment of this Act.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act.

EXTENDED MEDICAID COVERAGE FOR THE SEVERELY MEDICALLY IMPAIRED

SEC. 29. (a)(1) Section 1902 of the Social Security Act is amended by adding after subsection (h) (added by section 14(b) of this Act) the following new subsection:

"(i) For purposes of this title, an individual shall be treated as an individual eligible for medical assistance under subsection (a)(10)(A) if—

"(1) supplemental security income benefits under title XVI would be payable with respect to the individual but for paragraph (4) of section 1611(e) (as added by the Supplemental Security Income Disability Amendments of 1979), or

"(2) the individual is determined (in accordance with standards established by the Secretary)—

"(A) to have a severe medical disability and to meet, except for the individual's earnings, all nondisability-related requirements for eligibility to have supplemental security income benefits paid with respect to the indivdual under title XVI;

"(B) to have an income which does not, except for earnings, exceed the amount which would cause the individual to be ineligible for payments under section 1611(b) (if the individual were otherwise eligible for such payments);

"(C)(i) to have been receiving medical assistance under this title (as an individual eligible or considered eligible for such assistance under subsection (a)(10)(A)), (ii) without a determination under this paragraph the individual would not be eligible for continuation of such assistance, and (iii) the termination of such eligibility would seriously inhibit the individual's ability to continue employment; and

"(D) to have earnings which are not sufficient to allow the individual to provide for himself a reasonable equivalent of the benefits which would be available to the individual, in the absence of such earnings, under this title and title XVI.

For purposes of this subsection, an individual shall be considered to have a severe medical disability if the individual's impairment is sufficiently severe to result in a functional limitation requiring medical assistance in order for the individual to work.".

(2) Section 1902(a)(10) of such Act is amended—

(A) by striking out "and" before "(III)", and

(B) by inserting before the semicolon at the end the following: ", and (IV) the making available of medical assistance to individuals described in section 1902(i) shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of services of the same amount, duration, and scope, to any other individuals".

(b) Section 1902(a)(17) of such Act is amended—

(1) by striking out "and" before "(D)"; and

(2 by inserting before the semicolon at the end of clause (D) the following: ", and (E) in the case of individuals who have disabilities which are sufficiently severe to result in functional limitations requiring medical assistance in order that they may work, provide for the exclusion from income of such amounts as may be excluded by clauses (ii) through (iv) of section 1612(b)(4)(B) (as added by the Supplemental Security Income Disability Amendments of 1979) from the determination of income under title XVI".

(c) The first sentence of section 1905(a) of such Act is amended—

(1) by striking out "or" at the end of clause (vi),

(2) by inserting "or" at the end of clause (vii), and

(3) by adding after clause (vii) the following new clause:

"(viii) individuals who have impairments sufficiently severe to result in a functional limitation requiring assistance for the provision of such care and services in order for the individuals to work,".

(d) (1) The amendments made by this section shall (except as otherwise provided in paragraph (2)) apply to medical assistance to be provided under State plans, approved under title XIX of the Social Security Act, on or after the first day of the first calendar quarter that begins more than six months after the date of the enactment of this Act.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

CONTINUING MEDICAID ELIGIBILITY FOR CERTAIN INDIVIDUALS BY DISREGARDING CERTAIN INVOLUNTARY INCREASES IN INCOME

SEC. 30. The next to last paragraph of subsection (a) of section 1902 of the Social Security Act is amended by adding at the end the following new sentence: "In the case of an individual who, for a month after May 1980, was determined to be eligible for medical assistance under the plan and was receiving a monthly insurance benefit under title II of this Act or under the Railroad Retirement Act of 1974, or an annuity under subchapter III of chapter 83 of title 5, United States Code (relating to civil service retirement), or compensation, dependency and indemnity compensation, or a pension, under chapter 11, 13, or 15 of title 38, United States Code (relating to veterans and other persons) and who (but for this sentence) would have become ineligible for such medical assistance in the subsequent month because of an increase in the amount of such benefit or annuity due to an increase in a cost-of-living or price index, or because of an annual, general increase in the amount of such compensation or pension, respectively, becoming effective in such subsequent month, for purposes of establishing the individual's eligibility for medical assistance under the plan for such subsequent month (and each month thereafter until the first month in which the individual otherwise becomes ineligible for such assistance) there shall not be included in the individual's income any such increase in the amount of such benefit, annuity, compensation, or pension which becomes effective in or after such subsequent month.".

LIMITATION ON MEDICAID ELIGIBILITY FOR INDIVIDUALS WHO DISPOSE OF RESOURCES

SEC. 31. (a) (1) Section 1902(a)(17)(B) of the Social Security Act is amended by inserting "(except as provided under subsection (j))" after "(B) provide for taking into account".

(2) Section 1902 of such Act is further amended by adding after subsection (i), added by section 29(a) of this Act, the following new subsection:

"(j)(1) Notwithstanding any other provision of this title (including subsection (f), but except as provided in paragraphs (2) and (4)) and to the extent permitted in this subsection, a State plan for medical assistance under this title may provide that an individual shall be ineligible for medical assistance, provided under a State plan approved under this title, for the period specified in paragraph (2) if—

"(A) within any twenty-four-month period that begins with or after the twenty-fourth month preceding the month in which he files an application for medical assistance under the plan, the individual (or another person whose resources are considered in determining the eligibility of the individual) disposed of resources which, if retained, would have caused the individual to be ineligible for such assistance, for the purpose of establishing eligibility for such benefits (and any disposition of resources within such period may be presumed to have been for such purpose unless the State is

furnished convincing evidence that the transaction was for some other purpose), and

"(B) the sum of—

"(i) the current market value of the individual's (or other person's) equity interest in such resources disposed of without any compensation, and

"(ii) the difference between the current market value of the individual's (or person's) equity interest in such resources disposed of for compensation and the amount of such compensation, exceeded $6,000.

"(2)(A) Except as provided in subparagraph (B), the period for which an individual is ineligible for medical assistance under a State plan by reason of the application of paragraph (1) shall be—

"(i) six months, if the sum described in paragraph (1)(B) is less than $12,000.

"(ii) twelve months, if the sum described in paragraph (1)(B) exceeded $12,000 but was less than $30,000, and

"(iii) twenty-four months, if the sum described in paragraph (1)(B) exceeded $30,000,

and shall begin with the month following the month in which such disposition occurred.

"(B) A period of ineligibility shall end after the month in which the individual (or other person) either (i) returns the resources, the disposition of which caused the ineligibility to occur or (ii) receives payment equal to the amount of any uncompensated interest described in paragraph (1)(B).

"(C) A State plan may provide for the waiver of the requirement of paragraph (1), or the reduction in the period of ineligibility imposed by this paragraph, in such cases as the State determines that such a waiver or reduction is justified.

"(3) If the eligibility of a person for medical assistance under this title is dependent upon the eligibility of another individual and that other individual is determined to be ineligible for medical assistance under paragraph (1) for a period of time, the person shall be ineligible for medical assistance for the same period of time.

"(4)(A) Except as provided in subparagraph (B), paragraph (1) shall not apply to individuals with respect to whom supplemental security income benefits are being paid under title XVI.

"(B) Subparagraph (A) shall not apply to a State which, pursuant to subsection (f), does not provide for medical assistance to all individuals with respect to whom supplemental security income benefits are being paid under title XVI.

"(5)(A) Notwithstanding any other provision of law, if an individual disposes of resources to another person which disposal, under this subsection, could make the individual ineligible for medical assistance from a State for a period, the State plan under this title may provide for the recovery from such other person of an amount equal to—

"(i) the cost of the medical assistance provided to the individual during or after such period, or

"(ii) the sum described in clauses (i) and (ii) of paragraph (1)(B) with respect to transactions between the individual and the person for such period,

whichever is less, except that the State may not initiate such an action for recovery more than three years after the last date in such period of ineligibility.

"(B) If a State recovers funds under subparagraph (A), it shall provide for notice to the Secretary of the amounts so recovered and the Secretary shall reduce the amount of payments otherwise provided to the State under this title by an amount equal to product of—

"(1) the amount so recovered, and

"(ii) the Federal medical assistance percentage of the State.".

(b)(1) Except as provided in paragraph (2), the amendments made by subsection (a) shall become effective on the first day of the first month beginning after the date of the enactment of this Act, and shall apply to dispositions of resources that occur (or occurred) on and after such date (before, on, or after the date of the enactment of this Act) as the State may specify.

(2) Section 1902(j)(5) of the Social Security Act shall apply to dispositions of property that occur on or after the date of the enactment of this Act.

ADJUSTMENT OF DOLLAR LIMITATION AND ELIMINATION OF SPECIAL LIMITATION ON MEDICAID PAYMENTS TO PUERTO RICO, THE VIRGIN ISLANDS, GUAM, THE NORTHERN MARIANA ISLANDS, AMERICAN SAMOA, AND THE TRUST TERRITORY OF THE PACIFIC ISLANDS

SEC. 32. (a)(1) The first sentence of section 1101(a)(1) of the Social Security Act is amended—

(A) by striking out "title V" and inserting in lieu thereof "titles V and XIX", and

(B) by striking out "American Samoa" and inserting in lieu thereof "the Northern Mariana Islands, American Samoa,".

(2) Subsection (c) of section 1108 of such Act is amended to read as follows:

"(c) The total amount certified by the Secretary under title XIX with respect to—

"(1) fiscal year 1980, for payment—

"(A) to the Commonwealth of Puerto Rico shall not exceed $60,000,000,

"(B) to the Virgin Islands shall not exceed $2,000,000,

"(C) to Guam shall not exceed $1,800,000,

"(D) to the Northern Mariana Islands shall not exceed $250,000,

"(E) to American Samoa shall not exceed $500,000, and

"(F) to the Trust Territory of the Pacific Islands shall not exceed $1,800,000; and

"(2) any subsequent fiscal year, for payment to the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, American Samoa, and the Trust Territory of the Pacific Islands shall not exceed the amount specified in subparagraphs (A), (B), (C), (D), (E), and (F), respectively, of paragraph (1) increased by a percentage equal to the percentage increase in the Consumer Price Index for all urban consumers (published monthly by the Bureau of Labor Statistics of the Department of Labor) between October 1980, and the first month of such fiscal year.".

(b) The first sentence of section 1905(b) of such Act is amended—

(1) by striking out "(1)", and

(2) by striking out ", and (2)" and all that follows through "shall be 50 per centum".

(c)(1) The amendment made by subsection (a) shall apply to fiscal years beginning after September 30, 1979.

(2)(A) Except as provided in subparagraph (B), the amendments made by subsection (b) shall apply with respect to care and services provided, under a State plan approved under title XIX of the Social Security Act, in a calendar quarter beginning after September 30, 1979.

(B) Each of the agencies administering or supervising the administration of the State plan, approved under title XIX of the Social Security Act, for the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or the Northern Mariana Islands may elect not to have the amendments made by subsection (b) apply to any care or services provided in its jurisdiction to an individual over a period of time beginning before October 1, 1979, and ending after October 1, 1979.

EXTENSION OF INCREASED FUNDING FOR LONG-TERM CARE FACILITY INSPECTORS UNDER MEDICAID

SEC. 33. (a) Section 249B of the Social Security Amendments of 1972 (Public Law 92-603) is amended by striking out "and ending September 30, 1980,".

(b) Section 1903(a)(4) of the Social Security Act is amended by inserting "and before October 1, 1983" after "during such quarter".

(c) The amendment made by subsection (b) shall apply to calendar quarters beginning on or after October 1, 1980.

EXTENSION OF INCREASED FUNDING FOR STATE MEDICAID FRAUD CONTROL UNITS

SEC. 34. Section 1903(a)(6) of the Social Security Act is amended by striking out "an amount equal to" and all that follows through "with respect to costs incurred" and inserting in lieu thereof the following:

"an amount equal to—

"(A) 90 per centum of the sums expended during such a quarter within the twelve-quarter period beginning with the first quarter in which a payment is made to the State pursuant to this paragraph, and

"(B) 75 per centum of the sums expended during each succeeding calendar quarter,

with respect to costs incurred".

MEDICAID PAYMENTS TO STATES (FUND DRAW DOWN)

SEC. 35. (a) Section 1903(d)(2) of the Social Security Act is amended by inserting "(A)" after "(2)" and by adding at the end thereof the following: "In determining the installments of payments to be made under this paragraph, the Secretary shall insure (except in the case of a State described in subparagraph (B)) that payments to States are not made before the time that checks issued by the State for the medical assistance or other expenditure for which the Federal payment is being made are cleared through the State depository for payment, and the Secretary shall provide that each State may, with the approval of the Secretary, designate an estimating procedure to be used to determine the amount of the Federal payment under this sentence.

"(B) In any State which has in its Constitution a provision prohibiting the issue of checks or warrants by State officials unless there are funds in the State Treasury to pay for them, the Secretary shall reduce the amount of payment otherwise obligated to be made to the State under this title by an amount equal to the amount of the interest on Federal funds held by the State in the period of time before the time the check or warrant is cleared through the State depository for payment. Such amount of interest shall be determined each calendar quarter and shall be based on the average of the bond equivalent of the weekly 90-day Treasury bill auction rates for the four most recent weekly auctions preceding the beginning of the quarter, less the reasonable cost of banking services.".

(b)(1) Except as provided in paragraph (2), the amendment made by subsection (a) shall apply to payments made on and after such date, not later than December 31, 1980, as the Secretary shall establish.

(2) If the Secretary determines that payment cannot be made to a State in accordance with the third sentence of section 1903(d)(2) of the Social Security Act (as added by subsection (a)) on account of the need for State legislation by such State, the amendment made by subsection (a) shall not become effective with respect to payments made to that State until the first day of the first calendar quarer beginning after the close of the first regular session of the State legislature which begins after the date of the enactment of this Act.

CHANGE IN CALENDAR QUARTER FOR WHICH SATISFACTORY UTILIZATION REVIEW MUST BE SHOWN TO RECEIVE WAIVER OF MEDICAID REDUCTION

SEC. 36. Section 1903(g)(3)(B) of the Social Security Act is amended—

(1) by striking out "October 1, 1977" and inserting in lieu thereof "January 1, 1978", and

(2) by striking out "the calendar quarter ending on December 31, 1977" and inserting in lieu thereof "any calendar quarter ending on or before December 31, 1978".

DEMONSTRATION PROJECTS FOR REQUIRING SECOND OPINIONS FOR CERTAIN ELECTIVE SURGICAL PROCEDURES UNDER MEDICARE AND MEDICAID

SEC. 37. (a)(1) Part A of title XI of the Social Security Act is amended by inserting the following new section after the section added by section 25(a)(2) of this Act:

"DEMONSTRATION PROJECTS FOR REQUIRING SECOND OPINIONS FOR CERTAIN ELECTIVE SURGICAL PROCEDURES UNDER MEDICARE AND MEDICAID

"SEC. 1130. (a)(1) The Secretary is authorized to make grants to, and enter into contracts with, public and private non-profit entities, including professional standards review organizations designated (conditionally or otherwise) under part B of this title and medical societies, for the conduct of demonstration projects for the purpose of determining the cost-effectiveness and appropriateness of requiring that a second opinion with respect to specified elective surgical procedures (defined in subsection (f)(1)) be provided before payment may be made under title XVIII or under a State plan approved under title XIX with respect to the performance of the procedure.

"(2) To the extent feasible, the Secretary shall provide under this section for—

"(A) demonstration projects applicable to all specified elective surgical procedures proposed to be furnished to individuals entitled to hospital insurance benefits under part A, and enrolled under the supplementary medical insurance program under part B, of title XVIII of this Act, and

"(B) demonstration projects applicable to all specified elective surgical procedures proposed to be furnished to individuals eligible for medical assistance under State plans approved under title XIX of this Act.

"(3) The Secretary shall provide, to the extent feasible—

"(A) for at least seven demonstration projects under this section,

"(B) that the number of such projects conducted be equally divided between projects described in paragraph (2)(A) and projects described in paragraph (2)(B), and

"(C) for the conduct of such projects in a variety of geographic settings and covering a variety of sizes of populations, in order to determine the relative effectiveness of requiring second opinions in different areas of the country and under programs of different sizes.

"(b)(1) No grant may be made or contract entered into under this section unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary may provide.

"(2) The amount of any grant or contract under this section shall be determined by the Secretary.

"(3) Grants and payments under contracts made for demonstration projects and related administrative expenses (including expenses for analysis of data) described—

"(A) in subsection (a)(2)(A) shall be made in appropriate part from the Federal Hospital Insurance Trust Fund (established by section 1817) and the Federal Supplementary Medical Insurance Trust Fund (established by section 1841), and

"(B) in subsection (a)(2)(B) shall be made from funds appropriated under title XIX of this Act.

Grants and payments under contracts may be made either in advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this section.

"(4) In addition to any other authority provided under part B of this title, professional standards review organizations designated (conditionally or otherwise) under such part are authorized to receive grants and enter into contracts for demonstration projects under this section.

"(5) For administrative expenses (including analysis of data) associated with demonstration projects under this section, there is authorized to be appropriated for fiscal year 1981 an amount, not to exceed $7,000,000, to remain available until expended.

"(c) No grant or contract shall be made with respect to a demonstration project under this section unless the project meets the following requirements:

"(1) The project must potentially apply to a sufficiently large population of individuals eligible for benefits under part A of title XVIII (in the case of a project described in subsection (a)(2)(A)) or under the State plan (in the case of a project described in subsection (a)(2)(B)) for specified elective surgical procedures recommended during a two-year period, so as to provide for statistically valid data to properly evaluate the project.

"(2)(A) The project must provide (through the entity or the Secretary) for notice to the applicable population, and, to the extent feasible, to physicians and hospitals which may provide specified elective surgical procedures for such population, of the existence of the demonstration project and the requirement of subsection (d) for a second opinion as a condition of payment for such procedures, and must include in such notice made to the applicable population a general description of the procedure and techniques available for the treatment of the condition for treatment of which a specified elective surgical procedure has been recommended.

"(B) The project must provide for making available to individuals covered under the project lists of qualified physicians who have indicated that they will provide, in accordance with the provisions of the project, written opin-

ions with respect to the necessity and appropriateness of particular specified elective surgical procedures.

"(3) To the extent practicable and consistent with the protection of patient privacy, the project must be so designed as—

"(A) to prevent the qualified physician providing the second or third opinion from knowing the identity of the physician who provided a previous opinion with respect to that procedure, and

"(B) to avoid duplication of laboratory and other tests required in order to render such an opinion.

"(4) The project must provide that for the transmittal to the Secretary—

"(A) of interim data on the project's performance not later than eighteen months after the date the project is initiated, and

"(B) of final data on its performance not later than six months after the end of the two-year period described in paragraph (1).

"(d)(1) Notwithstanding any other provision of law (except as provided in paragraph (2)), if a specified elective surgical procedure to be furnished to an individual is covered under a demonstration project under this section applicable to title XVIII or to a State plan approved under title XIX, no payment may be made under such title or plan, respectively, with respect to the procedure unless the individual has been furnished, before the procedure is undertaken, at least—

"(A) one written opinion by a physician described in subsection (f)(2)(A), and

"(B) one written opinion by a qualified physician (as defined in subsection (f)(2)),

based on all factors deemed relevant to the determination, respecting the necessity and appropriateness of the procedure.

"(2) Paragraph (1) shall not apply—

"(A)(1) in the case of a demonstration project described in subsection (a)(2)(A), to procedures furnished by or through a health maintenance organization under a risk sharing contract entered into with the Secretary pusuant to section 1876(i)(2)(A), or

"(ii) in the case of a demonstration project described in subsection (a)(2)(B), to procedures furnished by or through a health maintenance organization which provides to the enrollees, on a prepaid capitation risk basis or any other risk basis, such procedures; and

"(B) in the case in which the patient is unable, because of severe physical or cognitive limitations, to understand the requirement of such paragraph or in such other cases as the Secretary determines that equity requires that such paragraph not apply.

"(e) The Secretary shall analyze the data on demonstration projects transmitted to him under this section and shall submit to the Congress—

"(1) not later than two years after the date of the enactment of this Act, an interim report on the demonstration projects assisted under this section, and

"(2) not later than four years after the date of the enactment of this Act, a final report on the demonstration projects assisted under this section.

such final report shall include such recommendations for changes in legislation with respect to imposing the requirement described in subsection (d) with respect to some or all of the specified elective surgical procedures as the Secretary determines to be appropriate.

"(f) For purposes of this section:

"(1) The term 'specified elective surgical procedure' means—

"(A) in the case of a demonstration project applicable to the medicare program—

"(i) cholycystectomy,

"(ii) menisectomy,

"(iii) prostatectomy,

"(iv) cataract surgery,

"(v) hemorrhoidectomy, and

"(vi) excision of varicose veins; and

"(B) in the case of a demonstration project applicable to State plans approved under title XIX of this Act—

"(i) hysterectomy,

"(ii) menisectomy,

"(iii) submucous resection,
"(iv) hemorrhoidectomy,
"(v) excision of varicose veins, and
"(vi) tonsillectomy and adenoidectomy,

if such procedures are medically necessary to treat other than an emergency medical condition. In addition, such term includes such other elective surgical procedures as the Secretary, in his discretion, determines to be appropriate.

"(2) The term 'qualified physician' means, with respect to an opinion on a specified elective surgical procedure for treatment of a medical condition of a particular patient, a physician who—

"(A) is a board-eligible or certified specialist with respect to the procedure or with respect to treatment of the medical condition or who possesses such other qualifications with respect to such procedure or treatment as the Secretary may specify;

"(B) agrees not to perform the surgical procedure for which the opinion is sought (except under emergency conditions); and

"(C) is not affiliated with a physician who provided a previous opinion with respect to such treatment of such patient.".

(2) The Secretary of Health and Human Services is not authorized to make grants or enter into contracts under section 1130 of the Social Security Act until October 1, 1980, and any projects under such grants or contracts shall not be construed to be subject to any of the requirements of part 46 of title 45, Code of Federal Regulations (applicable to research, development, and related activities in which human subjects are involved).

(b)(1) Section 1861(q) of such Act is amended by inserting "(including consultation as to the necessity and appropriateness of elective surgical procedures)" after "consultation".

(2)(A) Section 1833(a)(1) of such Act is amended—

(i) by striking out "and" before clause (E), and

(ii) by adding at the end thereof the following:

"(F) with respect to a second or third opinion as to necessity and appropriateness of specified elective surgical procedures described in section 1130(f)(1)(A), the amounts paid shall be equal to 100 percent of the reasonable charge for such opinion, and".

(B) the first sentence of section 1833(b) of such Act is amended by striking out "and" before clause (2) and by inserting before the period the following new clause: ", and (3) such total amount shall not include expenses incurred for a second or third opinion described in subsection (a)(1)(F) for an elective surgical procedure".

(3)(A) Section 1842(b)(3)(B) of such Act is amended by inserting "in paragraph (6) of this subsection or" after "(except as otherwise provided".

(B) Section 1842(b) of such Act is further amended by adding after paragraph (5) the following new paragraph:

"(6) No such contract shall provide for payment for a second or third opinion described in section 1833(a)(1)(F) on a basis other than that described in clause (ii) of paragraph (3)(B).".

(4) The amendments made by this section shall take effect with respect to opinions provided on or after the first day of the first month beginning after the date of the enactment of this Act.

(c)(1) Section 1903(a) of such Act is amended by redesignating paragraph (7) as paragraph (8) and by inserting after paragraph (6) the following new paragraph:

"(7) an amount equal to 90 per centum of the sums expended during such quarter which are attributable to the performance of a second or third opinion as to necessity and appropriateness of specified elective surgical procedures described in section 1130(f)(1)(B); plus".

(2) Sections 1903(i)(1) of such Act is amended by striking out "and fifth" and inserting in lieu thereof ", fifth, and ninth".

(3) The amendments made by this section shall apply to calendar quarters beginning on or after October 1, 1980.

APPLICATION OF INFORMED CONSENT TO CERTAIN DEMONSTRATION PROJECTS

SEC. 38. Notwithstanding section 37(a)(2) of this Act and section 1130(d)(1) of the Social Security Act, a demonstration project under section 1130 of the Social Security Act shall not apply to an individual unless the individual has

provided a written and legally effective informed consent, described in section 46.103(c) of title 45, Code of Federal Regulations, to participate in the project.

CONTINUED USE OF DEMONSTRATION PROJECT REIMBURSEMENT SYSTEMS

SEC. 39. (a) Section 1814(b) of the Social Security Act is amended—

(1) by inserting "except as provided in paragraph (3)," in paragraph (1) before the "lesser",

(2) by striking out the period at the end of paragraph (2) and inserting in lieu thereof "; or", and

(3) by adding at the end thereof the following new paragraph:

"(3) if some or all of the hospitals in a State have been reimbursed for services (for which payment may be made under this part) pursuant to a reimbursement system approved as a demonstration project under section 402 of the Social Security Amendments of 1967 or section 222(a) of the Social Security Amendments of 1972, if the rate of increase in such hospitals in their costs per hospital inpatient admission of individuals entitled to benefits under this part over the duration of such project was equal to or less than such rate of increase for admissions of such individuals with respect to all hospitals in the United States during such period, and if either the State has legislative authority to operate such system and the State elects to have reimbursement to such hospitals made in accordance with this paragraph or the system is operated through a voluntary agreement of hospitals and such hospitals elect to have reimbursement to those hospitals made in accordance with this paragraph, then such hospitals shall continue to be reimbursed under such system until the Secretary determines that—

"(A) a third-party payor reimburses such a hospital on a basis other than under such system, or

"(B) the rate of increase for the previous three-year period in such hospitals in costs per hospital inpatient admission of individuals entitled to benefits under this part is greater than such rate of increase for admissions of such individuals with respect to all hospitals in the United States for such period.".

(b) Section 1902(a)(13)(D) of such Act is amended by inserting before the semicolon at the end the following: ", except that in the case of hospitals reimbursed for services under part A of title XVIII in accordance with section 1814(b)(3), the plan must provide for payment of inpatient hospital services provided in such hospitals under the plan in accordance with the reimbursement system used under such section".

I. Purpose and Legislative Background of the Bill

The purpose of this legislation is to make various benefit changes and administrative improvements in the Medicaid and Medicare programs. Provisions of the bill either affect only the provisions of the Medicaid program, or affect those areas where Medicare and Medicaid have common provisions or requirements, such as PSRO requirements, determination of reasonable cost for inpatient hospital services paid for under the two programs, audits, certification of long-term care facilities, and various provisions relating to fraud. Experience with Medicaid and Medicare has indicated that changes are needed, particularly to improve the administrative effectiveness of the programs. The Committee believes that H.R. 4000, as reported, reflects a careful distillation of recommendations for addressing some of the more urgent operational problems of these two programs.

H.R. 4000 was introduced on May 8, 1979. It was the subject of hearings before the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce on October 16, 19, 22, and 23, 1979. The Subcommittee on Health and the Environ-

ment considered the bill and amendments thereto, and reported H.R. 4000 with an amendment in the nature of a substitute by a roll call vote of 11 to 0 on January 31, 1980. It was considered by the Committee on Interstate and Foreign Commerce on February 27 and 28, and March 4, and the full Committee ordered it reported with amendments, by voice vote on March 4, 1980.

II. Summary of the Bill

As reported, H.R. 4000 includes provisions relating to the operation of the Professional Standards Review Organization (PSRO) program, the availability and quality of long-term care services (including provision for the use of excess hospital beds as long-term care beds on a swing-bed basis), additional protection against fraud and abuse in the medicare and medicaid programs, a voluntary certification program for private insurance supplementing medicare, and a revision in the current method for reimbursing health maintenance organizations (HMO) under medicare. Additionally, it affects Medicare payments for the services of teaching physicians, makes various changes regarding standards for and payments to clinical laboratories, provides for inclusion of the services of nurse midwives in the Medicaid program, improves Medicaid coverage for the severely disabled, allows States to deny Medicaid eligibility to persons who dispose of assets in order to qualify for medical assistance, protects individuals from losing their Medicaid coverage because of cost-of-living increases in social security, veterans and civil service retirement programs, and increases or continues the Federal support for Medicaid long-term care inspectors, State fraud units, and Medicaid programs in Guam, Puerto Rico, and the Virgin Islands.

The PSRO provisions of the bill are designed to improve PSRO performance by focusing peer review activities on areas of abuse, increasing nonphysician participation in the development and implementation of peer review activities and tightening administration of the program.

The provisions dealing with long-term care are intended to assure that skilled nursing facilities meet quality standards while at the same time minimizing some of the administrative burdens currently imposed on such facilities. Since there is considerable concern about the availability of skilled nursing facility services, the bill directs the Secretary to study the causes of the present scarcity of available skilled nursing home beds for medicare and medicaid beneficiaries and the extent to which existing laws and regulations contribute to this problem. The bill also authorizes, for purposes of medicare and medicaid reimbursement, the use of acute care beds by hospitals to provide skilled nursing care services that would otherwise be covered if furnished in a skilled nursing facility.

The provisions dealing with Medicaid eligibility and services are designed to eliminate eligibilty abuses, allow greater use of alternate practitioners where appropriate, and provide more reasonable conditions for coverage of the severely disabled and the elderly.

A summary of the provisions of the bill follows:

SHORT TITLE (SECTION 1)

This Act may be cited as the "Medicare and Medicaid Amendments of 1980."

EXPANDED MEMBERSHIP OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (SECTION 2)

The bill authorizes each professional standards review organization (PSRO) to offer membership, at its own option, to nonphysician health professionals who hold independent hospital admitting privileges.

Under present law, membership in a professional standards review organization is limited to licensed doctors of medicine or osteopathy engaged in the practice of medicine or surgery in the organization's area. However, the provision of health care services furnished in a hospital setting may involve orders by independent health professionals other than physicians; for example, dentists and podiatrists. Since such health professionals hold hospital admitting privileges in many jurisdictions and order services for which payment may be made under medicare and medicaid, the Committee believes it would be appropriate to provide the opportunity—consistent with established professional relationships in each community—for such professionals to participate in the evaluation of these services as members of the PSRO. It is expected that such membership, where the invitation is extended by the PSRO, would be made available under the same general conditions now applicable to doctors of medicine or osteopathy. And the same requirements would apply; no independent health professional would review services that he or she delivered, for example. Additionally the bill retains the requirement of existing law that only doctors of medicine or osteopathy may make final determinations with respect to the services performed by other M.D.'s or D.O.'s.

The Committee believes that inclusion of consumer representatives on the boards of local PSRO's should be left to the option of each organization. Many PSRO's have already, on a voluntary basis, invited consumer representatives to sit on their boards. The Committee believes that such voluntary actions should be encouraged.

REGISTERED NURSE AND DENTIST MEMBERSHIP ON STATEWIDE COUNCIL ADVISORY GROUP (SECTION 3)

The bill provides that at least one registered professional nurse and one dentist would have to be included in the membership of the advisory group to each Statewide Professional Standards Review Council.

Under present law, the advisory group to a Statewide Council must be composed of representatives of health care practitioners (other than physicians) and health care institutions. In recognition of the impact the nursing and dental professions have on the delivery and quality of care, the Committee believes it is desirable to require each Statewide Council advisory group to include, in addition to representatives of other appropriate professional disciplines, at least one registered professional nurse and one dentist.

NONPHYSICIAN MEMBERSHIP ON NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL (SECTION 4)

Under the bill, the membership of the National Professional Standards Review Council would be expanded to include a dentist, a registered professional nurse, and one other nonphysician health professional.

Under present law, membership on the National Council, which advises the Secretary on policy and administrative matters relating to the PSRO program, is limited to doctors of medicine and osteopathy. The Committee believes, however, that since the National Council is responsible for providing policy and administrative advice on all services covered under medicare and medicaid, including services furnished by nonphysician health professionals, such a limitation on membership detracts from the effective performance of the Council's function. Providing for the membership of representatives of the nursing, dental and other health care professions would enhance the exchange of professional judgments on standards and utilization of services among these disciplines.

The Committee expects that the Secretary, in selecting the member to represent the several nonphysician health disciplines, will develop a selection process that will assure both the equitable rotation of the position among the recognized scientific health care disciplines and the selection of a representative of recognized standing and distinction in his or her chosen scientific field.

EFFICIENCY IN DELEGATED REVIEW (SECTION 5)

The bill provides for PSRO's to delegate their review functions to utilization review committees of hospitals, but only when the utilization committee demonstrates its capacity to carry out the required activities effectively, efficiently, and in timely fashion.

Under present law, PSRO's consider only effectiveness and timeliness of review in making delegation decisions. The Committee is concerned that, although hospital utilization review committees may be able to demonstrate effectiveness and timeliness, they may not in all cases be able to undertake these review activities as economically (on a cost per review basis) as the PSRO serving that hospital's area. Where this is the case, the Committee intends that the PSRO undertake the review activities. Accordingly, the Committee has added "efficiently" to the standards that a hospital utilization review committee must meet in order to continue to conduct delegated reviews.

When the PSRO law was enacted, PSRO's were not responsible for delegated hospital review budgets. Currently, however, PSRO's are limited in how much they can spend on review and PSRO's must negotiate review budgets with delegated hospitals. Although PSRO's have been negotiating lower unit cost rates with hospitals, based on hospital financial reports fiscal intermediaries can reimburse hospitals at higher rates than those negotiated. Delegated hospitals therefore have little incentive to hold their expenditures to the negotiated level. The only option available to PSRO's interested in withdrawing delegation to control costs is to demonstrate that the delegated review had been ineffective.

The Committee supports measures to control PSRO review costs and feels that it is necessary to consider the cost of review in making decisions about delegation. This will enable medicare and medicaid to achieve the most efficient conduct of effective review.

REQUIRED ACTIVITIES OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (SECTION 6)

The bill provides that, in order to obtain full designation, a conditionally designated PSRO must, at a minimum, satisfactorily conduct reviews of routine inpatient health care services provided to medicare or medicaid beneficiaries by or in hospitals in its area. The bill eliminates the requirement of current law that a PSRO must review long-term care services in order to be fully designated and must, if capable, review ambulatory care services within two years of becoming fully designated. In addition, the bill directs the Secretary to establish a program for the evaluation of the cost-effectiveness of review of particular health care services by PSRO's, and to require PSRO's to conduct review of additional health care services (except as part of the evaluation program) only where such review has been found to be cost-effective or yields other significant benefits. Finally, the bill authorizes the Secretary to designate another qualified PSRO to conduct reviews of particular services not yet being performed by designated PSRO's.

Under present law each PSRO is required to assume review responsibility for care (including physicians' services) delivered by or in all types of institutions within four years of receiving conditonal designation. The law further permits an extension for two additional years of a conditionally designated PSRO's trial period if failure to implement reviews in all types of institutions is due to causes beyond the PSRO's control. Within two years of receiving full designation, however, the Secretary must require those PSRO's with the capability to review ambulatory care services to assume this responsibility.

The Committee generally favors the expansion of PSRO review activities into areas other than routine inpatient hospital services. The Committee recognizes, however, that the expansion contemplated by current law would be premature in the absence of evidence that expanded review would be cost-effective or would offer other significant benefits. Accordingly, the bill requires the Secretary to establish an evaluation program to determine whether long term, ambulatory, and ancillary care reviews are cost-effective. In designing the evaluation program, the Secretary is directed to ensure that a statistically valid method is used to choose which PSRO's will and will not be required to implement the particular type of review being evaluated. Any statistically valid method should have at least the following characteristics:

—The creation of an "experimental" group of PSRO's that implement the new review activity, and a "control" group of PSRO's that do not implement the new activity;

—The selection of the experimental and control groups in such a way as to maximize the similarity between the two groups in the period before the experimental group implements the new activity; and

—The selection of the experimental and control groups in a way which permits a comparison that is, in the statistical sense, unbiased.

The Committee recognizes that studying the utilization of health care services is a very complex undertaking and it is often difficult to make definitive determinations regarding cause and effect in this area. The Committee further recognizes that it will be difficult to design a statistically valid study because of the many factors which can affect utilization and quality practices and any resulting changes in these practices. The Committee, however, encourages the Secretary to control for as many extraneous factors as possible in studying PSRO impact in the long term and ambulatory care settings and on ancillary services. The Committee further recognizes that studies reported in the professional literature, or other evaluations, may also be used in determining whether review of particular health services is cost-effective or yields other significant benefits if such studies or evaluations are of comparable reliability to the studies required under the evaluation program.

These new requirements reflect the concern of the Committee that the effectiveness of PSRO review activities must be demonstrated more persuasively than has been possible in the past. Evaluations carried out to date by the Health Care Financing Administration and by the Congressional Budget Office of PSRO review of admissions and lengths of stay in acute-care hospitals suggests that such review may reduce utilization. The CBO has also concluded that the best estimate is that the net savings generated by the PSRO program are about 30 percent less than program costs, whereas the Health Care Financing Administration evaluations have concluded that the program is cost effective. Both the CBO and HCFA estimates, however, rest on controversial assumptions and are open to considerable error. The Committee bill is designed to address this problem by mandating that valid evaluations be carried out before PSRO review of new services is generally required.

Based on a study outcome that PSRO review is cost effective or yields other significant benefits, the Secretary could require PSRO's to implement those types of review addressed in the study. Examples of other significant benefits that might be identified, and would justify requiring PSRO implementation of these types of review, would be demonstrated positive impacts on the quality of patient care, shifts in utilization to appropriate care settings, or reductions in the use of inappropriate treatment or services.

It is the Committee's intention that PSRO's which are now doing additional kinds of review of which on their own initiative request to implement ancillary, long term, or ambulatory care review should be funded. The Committee feels that such funding should be continued and encouraged to enable PSRO's to carry out types of review directed at particular problems in their areas or to reward PSRO's which have demonstrated positive performance in the area of hospital review. However, prior to the completion of the study, the Secretary could not require a PSRO to conduct a type of review it is not currently conducting if the PSRO does not want to initiate that particular type of review (unless it is necessary in order to obtain the data base

needed for evaluation). If the evaluation study finds that a particular type of review is cost-effective or yields other significant benefits, the Secretary could then require other PSROs to conduct it.

In cases where the Secretary has determined that reviews of a particular service are cost-effective or yield other significant benefits but the PSRO for the designated area does not have the capacity to undertake such additional review, the bill authorizes the Secretary to grant another qualified PSRO (in reasonable proximity to the providers and practitioners whose services are to be reviewed) to assume that authority and responsibility until the first PSRO has acquired the capacity to undertake such reviews.

RESPONSE OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS TO FREEDOM OF INFORMATION ACT REQUESTS (SECTION 7)

The bill provides that no PSRO will be required to make available any records pursuant to a request under the Freedom of Information Act until 180 days after the entry of a final court order requiring such disclosure.

Under current law, information and data collected and generated by PSRO's in the course of their review activities is, as a general rule, confidential. There are, however, several exceptions that permit disclosure of certain types of information to various persons or agencies for various purposes. For example, PSRO's are required to provide information to Federal and state fraud and abuse agencies to assist them in their investigative work. PSRO's are also required to make information available to state and local health planning agencies to assist them in carrying out health planning and related activities. The Department of Health, Education and Welfare is now in the process of implementing these various statutory requirements by regulation. See 44 *Fed. Reg.* 3058 (Jan. 15, 1979).

Recently a U.S. District Court ruled that some of the data held by PSRO's concerning patterns of practice of individual institutions and individual practitioners participating in Medicare and Medicaid were subject to disclosure under the Freedom of Information Act. *Public Citizen Health Research Group* v. *Department of HEW*, *Group* v. *Department of HEW*, C.A. No. 77–2093 (D.D.C., Sept. 25, 1979). None of the data sought in this litigation would identify individual patients or disclose their medical records. The Court stayed its order requiring release of the information at issue pending appeal, which has been taken.

This litigation has given rise to great concern among PSRO's and the medical community in general. There is considerable uncertainty as to what PSRO information will be disclosable, to whom, and under what circumstances. A resolution of these complex and competing considerations is clearly needed, so that all interested parties—PSRO's, physicians, program beneficiaries, other consumers, health planning agencies, fraud and abuse agencies, state Medicaid agencies, state licensure boards, state rate-setting agencies, and health and medical researchers—will know how PSRO data is to be treated.

Toward this end, the Committee has adopted a provision to assure that no PSRO could be required to disclose any data or information

pursuant to a Freedom of Information Act request until 180 days following the conclusion of the appeal and the entry of a final order in the *Public Citizen* case. This provision is not intended to make moot or otherwise reflect Congressional intent with respect to the decision in the appeal of this case or related cases. The Committee desires the benefit of full judicial consideration of the issues raised by that litigation while at the same time assuring Congress the opportunity to review the propriety of disclosure of whatever data is ultimately ordered released. In addition, the Committee expects that HEW will expedite its development of a disclosure policy under current law, so that the Congress will have the benefit of the Department's final views on these issues as well. Finally, this provision will also give the Congress time to study the recommendations of the National Academy of Sciences, which has agreed to undertake a study of the issues raised by this litigation. This provision is not intended to bar, or in any way restrict, access to PSRO data as provided for under section 1166 of the Social Security Act, section 1513(d) of the Public Health Service Act, or regulations implementing these sections.

CONSULTATION BY PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS WITH HEALTH CARE PRACTITIONERS (SECTION 8)

In lieu of the present requirement of formal advisory groups of health care practitioners to individual PSRO's, the bill would authorize the Secretary to establish more flexible guidelines to assure appropriate operational PSRO consultation with representatives of all health care disciplines on the performance of review activities.

Present law requires that advisory groups to PSRO's must be established and must be composed of not less than seven or more than eleven members who are representatives of health care practitioners other than physicians. Such formal advisory groups, however, have proved to be cumbersome and not totally effective in assuring appropriate consultation on operational matters. The Committee believes that more effective and practical arrangements could be achieved by authorizing the Secretary to establish and apply flexible guidelines relating to organizational relationships—including the range, frequency, and continuity of contacts—for assuring operational PSRO consultation with all health care disciplines.

The Committee notes that its intention is providing more flexibile authority to the Secretary is to allow the requirements for consultation with health care practitioners to be applied in a less burdensome manner than under current law. In specifying the frequency and manner of consultations, the Secretary would be expected to set general standards rather than specific formal requirements, and to encourage appropriate consultation without establishing rigid and unreasonable conditions.

REVIEW OF ROUTINE HOSPITAL ADMISSION SERVICES AND PREOPERATIVE HOSPITAL STAYS BY PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (SECTION 9)

Under the Committee's bill, PSRO's would be authorized to focus preadmission review on those areas of relatively frequent overutiliza-

tion—particularly routine hospital admission services and execessive preoperative stays—to assure that medicare and medicaid payments are made only when the routine tests and unusually long preoperative stays for elective conditions are medically appropriate.

Present program policies direct PSRO's to review the appropriateness of hospital services received by medicare and medicaid patients. This review has been limited largely to a review of the need for the patient to be admitted to the hospital and the appropriateness of the length of stay. However, a number of studies have demonstrated that unnecessary or avoidable utilization occurs with respect to certain hospital practices that may not have received sufficient attention by PSRO's, including: diagnostic tests routinely provided on admission without a physician's order; weekend elective admissions to hospitals which are not equipped or staffed to provide needed diagnostic services on weekends; and preoperative stays for elective procedures of more than one day without justification for the additional days. Consequently, the Committee is of the view that PSRO's should have the clear authority to undertake preadmission reviews of these areas of overutilization so that payments are not made for medically unnecessary routine hospital services or preoperative days. As part of this authority it is intended that PSRO's should be able to look carefully at surgical procedures to determine which might be appropriately performed on ambulatory basis in a hospital outpatient department, an ambulatory surgical center or a properly equipped physician's office.

However, the Committee believes that the decision as to whether to conduct such reviews should be that of each individual PSRO, and should be negotiated with the Secretary of HEW. Accordingly, the Committee's bill does not mandate PSRO reviews in these areas or authorize the Secretary unilaterally to require such reviews.

STUDY OF PSRO NORMS, STANDARDS AND CRITERIA (SECTION 10)

The bill requires the Secretary to conduct, in consultation with the National Professional Standards Review Council, a nationwide study of the differences in PSRO's medical criteria and length-of-stay norms. The Secretary would be required to report the findings of this study to the Congress within one year of enactment.

Present law requires PSRO's to use professionally developed norms of care based on typical patterns of practice in their areas, and also requires the National Council to exercise oversight and approval over PSRO norms which are significantly different from professionally developed regional norms.

The Committee believes that basing PSRO criteria and norms exclusively on typical practice patterns in the area may serve to perpetuate the status quo, including whatever inappropriate practices may be present in the area. While there are legitimate reasons for some variations in medical criteria and norms from area to area, there is also substantial evidence of widely different criteria and norms for similar patients under similar conditions. For example, the typical length of stay for a gall bladder removal varies by as much as 6 days in different sections of the United States. The intent of the study provided for in the bill is to determine what basis there is for such differ-

ences, so that the Congress can ascertain whether some steps should be taken to avoid the perpetuation of inefficiencies.

NONPROFIT HOSPITAL PHILANTHROPY (SECTION 11)

The bill provides that, in determining the amount of reimbursement for nonprofit hospitals under the medicare, medicaid, and maternal and child health (Title V) programs, the following items are not to be deducted from operating costs: (a) unrestricted grants, gifts, and income from endowments; (b) donor-designated or restricted grants, gifts, or income from endowment; (c) unrestricted grants or gifts, or income therefrom, designated by the hospital's governing board as unavailable for operating funds: (d) governmental grants that are not available for use as operating funds; (e) sale or mortgage of real estate or other capital assets acquired through gift or grant that are unavailable for use as operating funds (except gains and losses realized from the disposal of depreciable assets) ; and sinking funds established exclusively to make payments to third parties for financing capital improvements.

Under current law, grants, gifts, and endowment income designated by the donor to pay for specific operating costs are deducted from those costs in determining the reasonable cost of services for purposes of reimbursement under Medicare, Medicaid, and the Maternal and child health programs. The Committee heard testimony that this policy may discourage philanthropic contributions to nonprofit hospitals for specific operating costs. The Committee believes that philanthropic support for health care should be encouraged and expanded, especially in support of experimental and innovative efforts to improve the health care delivery system. Accordingly, the Committee bill provides that grants, gifts, and income from endowments, whether restricted by the donor or not, are not to be deducted from operating costs in determining the level of reimbursement under the federal payment programs.

The Committee notes that although this bill does not address the issue, the Committee is concerned that State policies should not inappropriately discourage philanthropic support of non-profit hospitals. For this reason, the Committee would encourage States to adopt policies to protect philanthropic giving.

CONSULTATIVE SERVICES FOR SKILLED NURSING FACILITIES (SECTION 12)

Under the bill, the provision of present law authorizing medicare reimbursement for consultative services furnished by State agencies to skilled nursing facilities would be repealed.

Under present law, the State agency responsible for determining skilled nursing facility compliance with medicare conditions of participation may furnish specialized consultative services, at the request of the facility, to help it achieve or maintain compliance with the conditions. However, since there have been no requests under this provision for medicare funding of consultative services, it is apparent that the provision is unnecessary. Moreover, the Committee believes that adequate provision has been made under the medicaid program for

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furnishing consultation to any skilled nursing facilities that might require such services.

STUDY OF NEED FOR DUAL PARTICIPATION OF SKILLED NURSING FACILITIES (SECTION 13)

The bill requires the Secretary to conduct a study of the causes for the present scarcity of skilled nursing home beds, including the extent to which existing laws and regulations (as well as other factors) discourage dual participation of skilled nursing facilities in the medicare and medicaid programs, and report the results of the study to Congress within one year after enactment.

Under present law, skilled nursing facilities are not required to participate in both the medicare and medicaid programs. As a result there are a number of areas of the country in which there are fewer beds available, either for medicare or medicaid beneficiaries, than might otherwise be the case if all skilled nursing facilities participated in both programs. While there are many opinions as to why a large number of facilities choose not to participate in both programs, the Committee believes there is little documentation and objective analysis of the reasons for this situation. To eliminate this gap in knowledge, the bill would direct the Secretary to conduct a thorough study of the situation and assess the feasibility and potential consequences of requiring dual participation. In conducting the study, the Secretary would be required to consult with professional organizations, private insurers, nursing home providers and consumers of skilled nursing services, and would be required to submit a report on the results of the study together with any recommendations for legislative changes.

ALTERNATIVE TO DECERTIFICATION OF LONG-TERM CARE FACILITIES OUT OF COMPLIANCE WITH CONDITIONS OF PARTICIPATION; LOOK BEHIND AUTHORITY (14)

The bill authorizes the Secretary and State Medicaid agencies to deny reimbursement for services furnished by a skilled nursing facility (SNF) or an intermediate care facility (ICF) for all medicare and medicaid beneficiaries admitted to the facility after the date the Secretary determines that it is substantially out of compliance with the conditions of, or requirements for, participation. In the case of a facility with deficiencies that immediately jeopardize the health and safety of its patients, the bill requires the Secretary and the State agency to decertify the facility, and while decertification is underway, to deny reimbursement for medicare and medicaid patients admitted subsequent to the determination of noncompliance. In addition, the bill authorizes the Secretary to "look behind" a State's survey of an SNF or ICF and, where the Secretary finds that a facility does not meet the conditions of, or requirements for, participation, to terminate the participation of the facility in medicare and medicaid.

At present, the only sanction available in many jurisdictions to penalize a skilled nursing facility which is out of compliance with the conditions of participation in the medicare and medicaid programs is to terminate that facility's participation in the program. Frequently,

this sanction involves an overriding hardship to program beneficiaries which makes its use desirable, if not impossible.

In the case of facilities that are substantially out of compliance but do not have deficiencies that immediately jeopardize the health and safety of their patients, the Committee's bill gives the Secretary authority to impose an intermediate sanction, short of the more drastic step of program termination. The Secretary would be expected to define by regulation the grounds for the imposition of an intermediate sanction. It is the expectation of the Committee that the existence of sanctionable deficiencies with the conditions of participation would generally be determined during the course of the formal State survey of the facility or HEW's compliance validation surveys. The denial of reimbursement for services furnished to medicare or medicaid beneficiaries admitted after a date designated by the Secretary would continue until such time as the deficiencies have been corrected or it is determined that good faith efforts to correct deficiencies are being made. This alternative sanction would be applicable for a limited period, not to exceed 12 months; thereafter, the bill would require the Secretary to decertify the facility.

In the case of facilities that are substantially out of compliance and have deficiencies that immediately jeopardize the health and safety of the patients, the Committee's bill directs the Secretary or State agency to decertify the facility and, while the decertification process is underway, to deny reimbursement for any services furnished to medicare or medicaid beneficiaries admitted after a designated date. This additional sanction would be applicable for the duration of the decertification or termination proceeding.

Under the Committee's bill, a facility would have an opportunity to develop and implement a plan for correcting its deficiencies, in accordance with existing medicare policies on the correction of provider deficiencies. Following the facility's failure to satisfactorily meet this requirement, the Secretary could apply intermediate sanctions, but only after the Secretary has provided the facility with an opportunity to present its case at an informal hearing consistent with current practices. If the facility seeks further administrative or judicial appeals, the sanction would remain in effect while the appeals were pending.

(It should be noted that it is not the intention of the Committee that a decision to impose sanctions shall preclude whatever right to judicial review of disputes of fact concerning noncompliance with conditions of participation which a facility otherwise has.)

The Secretary would be required to provide public notification to potentially affected beneficiaries of the date the sanction takes effect and the fact that no benefits will be payable on behalf of a beneficiary admitted to the facility after that date. (Benefits would continue to be paid on behalf of beneficiaries who were inpatients of the facility prior to the designated date.) The Secretary would be required to promulgate regulations setting forth the procedures for implementing this provision of the bill.

The Committee believes that the application of this sanction, in lieu of immediate decertification of a facility where life and safety are not threatened, would serve to protect beneficiaries both by giving

the skilled nursing facility an incentive to correct deficiencies in a timely manner and by forestalling the need for traumatic transfers of large numbers of patients during the time needed improvements are being made in the facility. However, the Committee believes that this sanction should not be used as an alternative in situations where a noncomplying facility's deficiencies place the health and safety of its patients in immediate jeopardy; instead, the response of the Secretary in such cases must be to deny all reimbursement for additional patients and to make appropriate arrangements for the orderly, planned transfer of existing patients.

It is recognized that several States presently have a full range of intermediate sanctions available, as part of their licensure authority, to impose against noncomplying facilities, including suspension of payments, bans on admissions, or even fines and penalties. The Committee bill is not intended to limit or preempt such authority.

The Committee's bill further authorizes the Secretary to make an independent and binding determination concerning the extent to which SNFs and ICFs that participate only in medicaid meet the requirements of participation in that program, and to terminate the eligibility of any facility that the Secretary finds does not comply with such requirements.

Under current law, the authority to determine whether an SNF or ICF that participates in medicaid but not medicare meets the requirements for participation in medicaid lies solely with the State medicaid agency. Based on current limited authority, the Secretary has issued regulations directed at assuring that States have followed Federal standards and norms in carrying out their survey and certification programs. However, the Committee is concerned that, without the authority to validate State agency compliance reviews and to make an independent judgment as to the extent of compliance by particular facilities, the Secretary lacks the means necessary to assure that Federal matching funds are being used to reimburse only those SNFs and ICFs that actually comply with medicaid requirements.

The Committee's bill would accordingly provide the Secretary with the authority to "look behind" a State agency's compliance review of individual SNFs or ICFs. Where the Secretary determines that a facility has failed to meet the applicable requirements, then, the State agency's determination to the contrary notwithstanding, the Secretary would be authorized to terminate the facility's participation in medicaid until the reason for the termination is no longer present and there is reasonable assurance that it will not recur. Under the bill, termination could not take effect until the affected facility had been provided an opportunity for a hearing on the Secretary's determination that it failed to meet the requirements for participation.

LIFE SAFETY CODE REQUIREMENTS (SECTION 15)

The bill authorizes the Secretary to determine in regulations when skilled nursing facilities participating in medicare and medicaid would be required to meet the provisions of revised editions of the Life Safety Code.

This provision of the Committee's bill would repeal the requirement of present law that a skilled nursing facility must meet the 1973

edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) and allow the Secretary to establish the time frame for application of the latest edition of the Code. Since the Life Safety Code is revised by the NFPA approximately every 3 years to accommodate changes in technology or philosophy, the statutory requirement that facilities meet a specified edition of the Code creates unnecessary administrative complications and burdens on providers. Although a 1976 Code is currently in general use and a 1980 Code is under development medicare and medicaid facilities are still required by law to comply with the 1973 edition of the Code. To eliminate this discrepancy and to permit the flexibility necessary to adjust to scientific developments in the fire protection field, the Committee's bill would allow the Secretary to revise the Life Safety Code requirement on a more timely basis without having to seek legislative changes. Moreover, such flexibility would reduce the regulatory burden on providers resulting from the application of unnecessary or out-of-date rules.

It is not the intent of the Committee's bill that the Secretary select among provisions from more than one edition of the Code in determining LSC requirements. Rather, one edition of the Code, in its entirety, would be adopted. The Committee expects that normally, the latest edition would be the one required. The Secretary would have authority, however, to review each new edition of the Code to assure that its provisions continue to afford adequate protection for the health and safety of patients. The Secretary would also have authority to require adoption of a new edition of the Code within a reasonable time frame, consistent with the capabilities of the States to conduct the necessary surveys of facilities using the new edition of the Code. Moreover, the Committee's bill would not limit the Secretary's present authority to use, wherever appropriate, the equivalency standards developed by the National Bureau of Standards and incorporated by the NFPA as part of the Life Safety Code.

The Committee recognizes the potential for certain problems arising as a result of revisions embodied in later editions of the Code that may upset structural accommodations previously made by providers at some cost to them. The Committee expects the Secretary to be fully cognizant to the impact of such changes on providers and to take them into account in revising the Life Safety Code requirement. The intent of the change made by the Committee's bill is to minimize regulatory burdens on facilities, consistent with protection of the health and safety of patients and to assure orderly adjustments to changing technology.

CRIMINAL STANDARDS FOR CERTAIN MEDICARE- AND MEDICAID-RELATED CRIMES (SECTION 16)

The bill provides that criminal penalties for solicitation or payment of kickbacks, bribes, rebates, or other remuneration in exchange for medicare or medicaid business apply only in cases where such conduct is undertaken knowingly and willfully.

Under current law, the solicitation or receipt of any remuneration in return for referring a medicare or medicaid patient to another party

or in return for purchasing, leasing or ordering any service or supply covered under medicare or medicaid constitutes a felony, punishable by a fine of up to $25,000 or 5 years imprisonment, or both. The offer or payment of kickbacks, bribes, or rebates for such purposes is also a felony, punishable to the same extent. The Committee is concerned that criminal penalties may be imposed under current law to an individual whose conduct, while improper, was inadvertent. Accordingly, the Committee's bill clarifies current law to assure that only persons who knowingly and willfully engage in the proscribed conduct could be subject to criminal sanctions.

EXCLUSION OF HEALTH CARE PROFESSIONALS CONVICTED OF MEDICARE OR MEDICAID RELATED CRIMES (SECTION 17)

Under the bill, the provisions of present law relating to the exclusion from participation in the medicare and medicaid programs of physicians and other practitioners convicted of program-related crimes would be broadened so as to apply to other categories of health professionals, such as administrators of health care institutions.

Under present law, medicare and medicaid payment may be denied for goods and services furnished by a physician or other practitioner convicted of a program-related crime. However, similar action cannot now be taken with respect to other health professionals (such as operators or administrators of health care facilities) who are convicted of program-related crimes. The Committee's bill would rectify this deficiency in the law. In the case of those profesionals who do not directly furnish medical care or services, payment would not be made to the provider for the cost of any services furnished to or on behalf of the provider by the convicted professional in connection with either program. (The provision of present law relating to a right to a hearing on a determination of the Secretary to bar an individual from participation would be retained.) The Committee's bill also clarifies the intent of present law that the Secretary is authorized to bar a professional who may have participated only in the medicaid or medicare program from participation in both programs.

REQUIREMENTS CONCERNING REPORTING OF FINANCIAL INTEREST (SECTION 18)

The present statutory requirements relating to the reporting of financial interest as a condition of participation in medicare and medicaid would be amended by the bill to provide that an entity would be required to report only those individual interests in mortgages or other obligations equal to at least $25,000 or 5 percent of the entity's total assets. Present law requires the reporting of all interests of 5 percent or more of any such obligation secured by property of the reporting entity, even where the obligation is secured by a small portion of the entity's assets.

The Committee's bill would also clarify the states' responsibility to require compliance with the disclosure requirements of present law as a condition of participation in the medicaid program.

WITHHOLDING OF FEDERAL SHARE OF PAYMENTS TO MEDICAID PROVIDERS TO RECOVER MEDICARE OVERPAYMENTS (SECTION 19)

The Secretary's authority under present law to recover overpayments under medicare, where a provider has withdrawn or has been terminated, by withholding the Federal share of medicaid payments to the provider's would be extended by the bill to instances where: (a) the provider continues to participate in medicare but at such a minimal level as to preclude recovery of the overpayment; and (b) where recovery of large medicare overpayments under part B to a physician or other health professional is precluded because the practitioner or professional is not participating in medicare (i.e., no longer accepts assignment for medicare claims).

Under present law, the Secretary can withhold the Federal share of medicaid payments from providers in order to recover medicare overpayments, but only where the provider has withdrawn or has been terminated from participation in the program. The purpose of this provision of the committee's bill is to prevent such a provider from circumventing the intent of the recovery provisions of present law by formally maintaining its status as a participating medicare provider while substantially reducing its acceptance of medicare patients. Similarly, the bill would permit recovery of medicare overpayments to physicians and professionals who subsequently elect not to accept assignment for medicare claims and thus preclude any recoupment of such overpayments through offsets against future medicare payments.

The Committee notes that it is not the intent of this section or the recovery provisions of the current law to penalize State medicaid programs by making them absorb the full cost of medicaid payments to these medicare providers who received overpayments under title 18. The Committee expects that the Secretary would provide adequate advance notice of no less than 60 days to the State concerning the providers who would be subject to the procedures for recovery of medicare overpayments through the withholding of the Federal share of the medicaid payment, so that the State would have sufficient opportunity to change its payment procedures to these providers to insure that the reimbursement would be limited only to the State share of the bill.

HOSPITALS PROVIDING LONG-TERM CARE SERVICES "SWING BEDS" (SECTION 20)

The bill authorizes the Secretary to enter into agreements with certain hospitals, for purposes of reimbursement under the medicare and medicaid programs, under which the hospital could use its beds on a "swing" basis as either acute or long-term care beds, depending on need. A simplified cost reimbursement formula would avoid the current requirement for separate patient placement within the hospital and separate cost finding. (This formula would also reflect the lower cost of providing less than acute care.) Hospitals which have been granted a certificate of need for the provision of long-term care services would be eligible to enter into such agreements.

Where a hospital does not have such an agreement, payment for long-term care services furnished to a beneficiary who remains in

the hospital because no long-term care beds are available in the community would be made at the average medicaid skilled nursing or intermediate care facility rate (as may be appropriate) if the hospital's average annual occupancy rate is below 80 percent and the hospital could obtain a certificate of need to provide long-term care services.

Patient days of care that are paid by medicare at the reduced rate would be counted against the beneficiary's eligibility for skilled nursing facility benefits. Similarly, the medicare skilled nursing facility benefit coinsurance rates would be applicable.

The Committee believes that a number of hospitals in areas where there is a scarcity of long-term beds could use their unoccupied acute care beds to provide a less intensive level of care. Under present law, however, such a lesser level of care furnished to medicare and medicaid patients in hospitals is not appropriately covered unless furnished in a distinct part of the hospital where beds are reserved solely for nursing care patients. The Committee's bill would allow such hospitals to use their acute care beds to provide nursing care services which would otherwise be covered under medicare or medicaid if the services were provided in a skilled nursing or intermediate care facility. In order to assure the quality and appropriate use of such services, nursing care services provided to medicare and medicaid beneficiaries in such a hospital would be subject to certain skilled nursing facility conditions of participation relating to social service staffing and functions and discharge planning that are not treated as specifically in the hospital conditions of participation. The conditions that the Committee expects the Secretary to apply include: (a) the social service provisions that require the facility to make an effort to identify the patient's social and emotional needs and to employ, or have a referral agreement with, a qualified social worker or social work agency; and (b) the requirement that the facility maintain an active discharge planning program. In addition, the Committee believes it would be desirable to encourage the facility's governing body to establish and direct the implementation of written policies regarding the rights of long-term care patients.

The Committee notes that this "swing bed" provision may not be appropriate under certain situations. A State in determining whether to issue a certificate of need for a hospital to provide long term care services should consider the cost of those services provided by a hospital compared to the cost of services which could be developed in a long term care facility. The role of the hospital and excess hospital capacity in this area must also be considered. It may be appropriate for a State to disapprove a certificate of need application from a hospital in conjunction with this "swing bed" provision because the facility should close or convert some or all of its capacity to other uses. In this connection the committee looks favorably upon the idea of including in a hospital's reimbursement an allowance for the capital and increased operating costs associated with the closing or conversion of underutilized bed capacity or services in hospitals.

In order to avoid imposing a possible disadvantage on institutions that have established "distinct part" skilled nursing facilities, the Committee's bill provides that the simplified "swing-bed" method of reimbursement would be made available under medicare and medicaid

for services furnished in such "distinct part" facilities. The Secretary would approve this alternative reimbursement method where the hospital demonstrates that its use would contribute significantly to efficient and effective administration and would be in the interest of program beneficiaries. Making the simplified reimbursement option available would put institutions with distinct part skilled nursing facilities on an even footing with the other hospitals that will be eligible for "swing-bed" reimbursement under the bill.

Where continued hospital stay in an institution that has not entered into a "swing-bed" agreement with the Secretary is necessitated by the unavailability of an appropriate long-term care bed in the community, and (i) the hospital's occupancy rate is below 80 percent and (ii) it could obtain a certificate of need, payment would be made at the same rate otherwise payable to a participating "swing-bed" hospital. It is the Committee's intent that this second standard, i.e., that the institution could have obtained a certificate of need, would be considered met if the State Health Planning and Development Agency had found in its current State Health Plan that a shortage of nursing home beds existed in the area in which the hospital is located, or if the agency determined that long-term care beds were not available in the area in institutions which would agree to accept medicare and/or medicaid reimbursement. It is not the intention of the Committee that the hospital must receive from the planning agency a formal decision relating to its specific case. Similarly, it is not the intent that the Secretary would be required to evaluate the local circumstances to determine if a certificate of need would have been given under State law.

In determining the appropriate rate of reimbursement for hospital patients receiving long-term care services where no swing-bed arrangement exists, the intermediary in the case of medicare or the State medicaid agency would be expected to determine on a case by case basis in accordance with standards established by the Secretary that no appropriate long-term care bed is available in an institution which will accept medicare and/or medicaid reimbursement. If it is determined that an appropriate long-term care bed is available, then the Committee expects that payment would not be made to the hospital for those patients needing only long-term care services (unless there was a swing-bed agreement or they were in a recognized distinct part). Further, the Committee notes that institutions which regularly receive payment for patients who do not need acute care but are receiving long-term care services in the hospital because no other bed is available in a skilled nursing facility should be encouraged to enter into a formal swing-bed arrangement.

If the hospital's occupancy rate is 80 percent or above, or it cannot obtain a certificate of need (presumably because there is a need for the hospital's acute care beds), payment would be made, as under present law, at the hospital rate for such period as it is medically determined the patient requires covered skilled nursing or intermediate care services and an appropriate bed is temporarily unavailable.

In adopting these provisions, it is the intent of the Committee both to allow a more flexible situation for hospitals providing long-term

care services when beds are not available in long-term care facilities and to reduce unnecessary expenditures at an acute care rate for hospital patients who are receiving only long-term care services. It is the Committee's intent that medicaid payments for such patients would also be reduced to the "swing-bed" rate. In past Court cases, decisions have been rendered requiring States to continue to reimburse at the acute care rate for patients in hospitals receiving only SNF services because no bed was available in a skilled nursing facility. At that time, the only reimbursement options were to pay the hospital rate or not pay at all. This bill is designed to provide States the more reasonable standard of paying at the swing-bed rate, paralleling the medicare procedure.

COORDINATED AUDITS UNDER THE SOCIAL SECURITY PROGRAM (SECTION 21)

The bill requires common audits of entities reimbursed on a cost-related basis under titles V (maternal and child health), XVIII (medicare), and XIX (medicaid), of the Social Security Act. The bill also requires the Secretary to undertake one or more demonstration projects with respect to such entities to determine the feasibility of a single coordinated appeal hearing to adjudicate disputed administrative cost items.

Currently, these programs generally provide for reimbursement of participating health care facilities on a reasonable cost or cost-related basis. To assure that payment of reasonable cost is achieved, a comprehensive provider audit program has been established. The medicare audits are mandated by law; the medicaid audits are required by regulation. At the present time, unless covered by a common audit agreement, providers have a separate audit conducted for medicare and medicaid. The duplicate auditing effort can be costly and time-consuming.

A voluntary common provider audit was established in 1968 by the Department of Health, Education and Welfare which established procedures to be followed, costs to be shared, method of payment for services and what coordination was necessary. Under the voluntary program, 37 States contracted with intermediaries for coordinated audits for some or all medicare—medicaid providers. Over half of the hospitals paticipating in Medicare were covered by those agreements. Under recently revised procedures authorizing freer exchange of audit information between the programs, all States have been negotiating new coordinated audit agreements with medicare intermediaries.

Under the new agreements, medicare will supply all of its audit information to the States free of charge. States will pay only the incremental costs to medicare intermediaries for auditing activities required solely for medicaid purposes. The Committee would expect the Secretary to continue to follow this way of allocating costs when common audits are required.

Duplication of identical or similar auditing procedures used for the purpose of determining reimbursement under various Federal programs is costly to both the programs and the entities participating in the programs. In order to eliminate this duplication, the Committee's bill requires that, if an entity provides services reimbursable on a cost-

related basis under titles V or XIX, audits of books, accounts, and records of that entity are to be coordinated through common audit procedures with audits performed for the purpose of reimbursement under title XVIII. Where a State declines to participate in such common audits, the Secretary is to reduce payments that would have been made to the State under titles V or XIX by any amount in excess of the amount that would have been apportioned to the State if it had participated in the audit.

Duplication of procedures for hearing and adjudicating appeals from audit findings may also be unnecessarily burdensome and costly. The Committee's bill directs the Secretary to establish one or more demonstration projects to determine the feasibility of linking a common audit with a single coordinated appeal procedure.

CERTIFICATION OF PRIVATE SUPPLEMENTARY HEALTH INSURANCE POLICIES "MEDIGAP" (SECTION 22)

The bill requires the Secretary to establish a certification procedure for health insurance policies offered by private insurance companies to supplement medicare. Under the procedure, which would be effective January 1, 1982, companies could submit policies to the Secretary for certification that the policy meets prescribed standards relating to benefits provided, loss ratios, preexisting conditions, cancellation clauses, simplicity of policy language and disclosure of information to potential purchasers. (Policies issued in any State which has implemented a regulatory program that requires compliance with minimum standards comparable to those included in the Committee's bill would be deemed to be certified.)

Under the bill penalties would be provided for: (1) furnishing false or misleading information for the purpose of obtaining certification; (2) misrepresentation as an agent of the Federal Government for the purpose of selling insurance to supplement medicare; and (3) knowingly selling a policy which substantially duplicates coverage already held. Such acts would be punishable upon conviction by a fine of not more than $25,000 and/or imprisonment for not more than five years. Under the bill, penalties would also be provided for certain "prohibited practices" with regard to mail order supplementary policies or certificates. The bill defines a prohibited practice to mean the advertising, solicitation, or offering for sale of a medicare supplemental policy, or the delivery of such a policy, into any State in which the policy has not been approved by the State Commissioner of Insurance. A policy will be deemed to have been approved by the State Insurance Commissioner (unless the State requests that the policy or certificate be subject to such State's approval) if: (1) it has been approved by the Secretary; (2) it has been approved in the States in which more than thirty percent of such policies are sold; or (3) the State Insurance Commissioner has the authority to review and approve or bar the policy from sale. Such acts would be punishable upon conviction by a fine of not more than $25,000 and/or imprisonment for not more than five years. The Committee intends that a policy which is certified by either the Secretary or a State meeting the Federal standards may bear the Secretary's emblem when sold in any other State as long as the terms of the policy are unchanged.

The Secretary would also be required to conduct a comprehensive study of existing State programs regulating insurance designed to supplement medicare and to submit recommendations by July 1, 1981, with respect to appropriate methods for assuming more effective regulation of such insurance.

Hearings conducted by both Houses of Congress have disclosed the existence of significant abuses and problems in the sale of private supplementary health insurance to aged medicare beneficiaries. Among the many problems identified were the dissemination of misinformation about the extent of insurance coverage provided, unethical sales practices, restrictive policy clauses, and complex and confusing poliy language. As a result of these disclosures, the Committee believes that a consensus has emerged about the critical need to: (1) eliminate the flagrant abuses resulting from unethical sales practices; (2) develop more effective ways for assuring informed choices by beneficiaries among the range of avaialble private policies; and (3) apply more effective approaches to assuring the development and implementation of acceptable minimum standards for these policies.

The Committee's bill would address these issues in several ways; first, by requiring the Secretary to establish a voluntary certification program under which policies meeting prescribed minimum standards would be certified by the Secretary and appropriate information disseminated to beneficiaries about the selection of a suitable supplementary policy (States would be encouraged to apply their own programs by deeming policies in States with comparable standards to be certified); secondary, by providing criminal penalties for acts involving the furnishing of fraudulent or misleading information for purposes of obtaining the Secretary's certification or of selling policies to beneficiaries; thirdly, by providing penalties for using prohibited practices in the sale of mail order policies or certificates; and finally, by requiring the Secretary to undertake a major study of the several current methods used by States to regulate the marketing of private supplementary insurance to the aged and to submit recommendations on further steps that might be taken to assure more effective State or, if necessary, Federal regulation of such insurance. The Secretary would also be required to report to the Congress on January 1, 1982 and periodically thereafter, but not less often than every two years, on the effectiveness of the certification procedure and to include in such reports his recommendation as to the need for continuing the procedure.

The Committee recognizes that these provisions of the bill do not represent a final solution to the serious problems of abuse in the marketing of private policies for the aged and the inadequacy of the protection afforded by a gerat many supplementary insurance policies. The Committee believes that additional information on how best to deal with these problems is needed and the Committee expects that the study the Secretary is directed by the bill to make will produce both the necessary data and relevant legislative recommendations. Nevertheless, the Committee believes the voluntary certification program represents a useful preliminary step toward the provision of some consumer protection and advice in the selection of appropriate policies.

The Committee also recognizes the efforts recently made by the National Association of Insurance Commissioners in designing and urging on States a model regulation for supplementary policies. The Committee's bill would lend support to these efforts by providing for automatic certification for policies issued in States which adopt the NAIC's model regulation, with the additional Federal standards provided by this bill. The Committee believes that until States take the steps necessary to assure aged beneficiaries the protection they need against deceptive marketing practices and inadequately designed policies there is an appropriate role for the Federal Government.

DEMONSTRATION PROJECTS RELATING TO THE TRAINING OF AFDC RECIPIENTS AS HOME HEALTH AIDES (SECTION 23)

The bill authorizes the Secretary to enter into agreements with up to 12 States, selected at her discretion, for the purpose of conducting demonstration projects for the training and employment of AFDC recipients as homemakers and home health aides. Ninety percent Federal matching would be provided under the States' medicaid programs for the reasonable costs (less any related fees collected) of conducting the projects. The projects would be limited to a maximum of 4 years plus an additional period of up to 6 months for planning and development and a similar period for final evaluation and reporting. The Secretary would be required to submit annual evaluation reports, and a final report on all the projects, to the Congress.

It has been estimated that as many as 40 percent of the aged and disabled now in high cost nursing care facilities do not necessarily have to be there—and would probably not be there if alternative supportive services to maintain them in their own homes were available. At the same time, there are many persons currently on the welfare rolls who, if they received appropriate training, could become gainfully employed members of ancillary health professions. The intent of the bill is to permit the Secretary to undertake several demonstration projects to assess the validity of these assumptions and the potential savings to the medicare and medicaid programs of reduced use of institutional care.

A State participating in the project would be required to establish a formal program, approved by the Secretary, to train participants in the provision of homemaker and home health aide services. The State would provide for the employment of those who complete the training program with public or (by contract) nonprofit private agencies engaged in furnishing such services on a part-time or intermittent basis to aged, disabled or other incapacitated individuals who in the absence of such services might otherwise require institutional care.

AFDC recipients entering such a training program would be considered to be participating in a work incentive program authored under part C of title VI of the Social Security Act. During the first year such an individual is employed under the program, he or she would retain medicaid eligibility and any eligibility he or she had prior to entering the training program for social and supportive services provided under part A of title IV. Federal funding would not

be available for the employment of any participant under the project after the participant has been employed for a 3-year period.

REIMBURSEMENT FOR HEALTH MAINTENANCE ORGANIZATIONS (HMO'S) (SECTION 24)

The bill would provide reimbursement for health maintenance organizations on the basis of a prospectively determined per capita amount equal to 95 percent of the cost of providing medicare benefits to beneficiaries outside the HMO. Any difference between the HMO's adjusted community rate (adjusted for the higher utilization of the elderly and disabled) and the medicare reimbursement would be returned to medicare beneficiaries in additional benefits.

Under present law, health maintenance organizations may contract for medicare reimbursement on either a cost or risk basis. However, only one HMO has opted to be reimbursed under the existing risk formula. HMO's have generally found the risk reimbursement formula unacceptable because retroactive adjustments are made which take into account the costs actually incurred by the HMO. The new risk formula would provide a prospectively determined per capital payment for each enrollee. Your Committee recognizes that HMO's, in the non-medicare portion of their business, receive a fixed, prospectively determined payment per enrollee which is not related to the amount of care. This payment per enrollee acts as a limit on HMO revenues, creating financial incentives for the organization to control costs and to provide only the least expensive service appropriate to the enrollees' needs. These incentives are passed on to the physician by paying him on a salary basis, providing a bonus or profit sharing arrangement when costs are kept low, or providing other meaningful incentives for him to control costs and utilization.

Under your Committee's bill, the rates of medicare payment under the risk contract would be set at 95 percent of the per capita amount that would be paid by medicare for services provided to an enrolled beneficiary (classified by actuarial factors such as age and sex) by other providers in the geographic area of the HMO. For example, the rate of payment for a 65 year old beneficiary would be lower than the rate for an 85 year old beneficiary.

The second important feature of the bill's risk reimbursement formula requires the HMO to provide to enrolled medicare beneficiaries increased benefits or reduced cost-sharing, to the extent that the medicare reimbursement exceeds the HMO's adjusted community rate. This approach would create incentives for medicare beneficiaries to enroll in HMO's and assure that the economies realized through HMO efficiencies, in excess of the HMO's usual profit and other retained funds, accrue to beneficiaries. The HMO would determine what additional benefits, reduced beneficiaries cost sharing or combination of the two are most appropriate for its medicare enrollees. The Secretary would be required to report to the Congress three years after enactment on the type and amount of additional benefits which are being provided. Your Committee's bill also requires the Secretary to study and report to the Congress the causes for beneficiary disenrollment from HMO's under medicare contracts, paying particular atten-

tion to the utilization and quality of services provided these beneficiaries and their medical condition prior to disenrollment.

Members of an HMO which has elected to be reimbursed under this risk formula could not receive medicare payments for services not furnished by or through the HMO; the HMO would be responsible for providing all medicare-covered services to medicare enrollees. However, medicare beneficiaries enrolled in an HMO at the time the new method was first applied to the HMO could choose to continue to seek medical care outside the HMO and be reimbursed by medicare in the current manner unless the Secretary, because of the administrative costs or other administrative burdens involved, required the new method to apply to all members of a particular HMO.

An HMO would be defined as a public or private organization which is organized under the laws of any state. It would include both federally qualified HMO's and other HMO's which are constituted in accordance with requirements spelled out in the bill. The Committee carefully developed these requirements so that HMO's which are not federally qualified would be eligible to participate in this new Medicare reimbursement system.

In some parts of the country HMO's have developed without the advantages of being federally qualified. If they realize their potential for operating in a cost efficient manner, they will exert strong competitive pressure on health insurance plans, and thus fee for service providers, to reduce the cost of health services and expand the services offered in their benefit plans. It is the Committee's view that these HMO's are capable of serving medicare beneficiaries as well as any other health care providers. It would be inappropriate and unnecessary to require these HMO's to become federally qualified in order to participate in this new medicare reimbursement scheme as long as there are assurances that their medicare and other enrollees are satisfied with the care they receive.

An HMO which is not federally qualified must meet five requirements. First, the organization must provide the following comprehensive range of health care services: physicians services, inpatient hospital services, laboratory, X-ray, emergency and preventive services and out of area coverage. Preventive health services would include services such as voluntary family planning, well child care, periodic health evaluation for adults, pediatric and adult immunizations. The organization either must provide these services to its enrolled members or otherwise make these services available to its enrolled members by arranging for their provision.

Second, the organization must be compensated (except for deductibles, co-insurance and co-payments) for the provision of health care services to a member by a fixed periodic payment which is unrelated to the frequency, extent, or kind of health care services actually provided to that member.

Third, the organized must provide physician services either (1) directly through physicians who are either employees or partners of the organization, or (2) through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis. If an HMO used such arrangements, the Committee intends for it to enter into contracts with the

individual physicians or group of physicians to insure that they would be available and accessible to the enrolled members. One of the most important features which distinguishes an HMO from a health insurance plan is that an HMO contracts with its members to make physicians available to them to provide necessary services while an insurance plan contracts with its insureds to pay for physicians' services if the insured individuals locate the physicians. If the HMO does not have contracts with its physicians it could not assure its members of the availability and accessibility of their physicians.

Fourth, the organization must assume full financial risk on a prospective basis for the provision of its health care services. Exceptions to this requirement are that the organization may obtain insurance or make other arrangements for the cost of providing health care services to any one enrollee in excess of $5000 a year, for the cost of out-of-area medically necessary services, and for up to 90 percent of the amount by which its costs for any fiscal year exceed 115 percent of its income for that year. The assumption of financial risk on a prospective basis is an essential characteristic of an HMO. Because HMO provides services within a fixed annual revenue ceiling it constantly seeks to control its costs. It is the Committee's view that an HMO cannot contain its costs if it does not promote efficient utilization of services and facilities by its physicians and other health care providers. The Committee intends for HMO's to use mechanisms, such as risk sharing, financial incentives or other incentives, with their physicians to encourage them to monitor utilization, achieve utilization goals and thereby control costs.

And fifth, the organization must make adequate provision against the risk of insolvency. Without this requirement individuals enrolled could be subject to the unexpected bankruptcy of their HMO and subsequent disruption of their health care services.

If an organization meets these five requirements it would be considered a health maintenance organization for purposes of reimbursement under medicare. In order to participate in medicare, however, it must also meet for its medicare beneficiaries certain conditions of participation.

There are eight conditions of participation. First, the HMO's minimum benefit package must include the services to which a medicare beneficiary is entitled. It may include additional health care services at the option of the medicare beneficiary or if the Secretary approves such additional services. The purpose of the provision is to allow the Secretary to approve a broader minimum benefit package only if the HMO is offering to the medicare beneficiary the same minimum benefit package it offers to its other enrollees. (The HMO could add even additional services would substantially discourage enrollment by medficiary). The Secretary's authority to approve a broader minimum benefit package is limited. If the Secretary determines that including additional services would substantially discourage enrollment by medicare beneficiaries, then the Secretary would not approve the addition. Under any circumstance the HMO is required to inform medicare beneficiaries of the portion of their premium rate or other charges which are applicable to any additional services. Under no circumstances could medicare beneficiaries' health status be considered

by the HMO in determining whether a beneficiary could enroll if a broader minimum benefit package is authorized by the Secretary.

Second, the HMO must limit the amount of premium or other payments charged to its medicare enrollees for their entitled benefits to the actuarial equivalent of medicare deductibles and coinsurance that would apply to these beneficiaries were they not enrolled in the HMO. Any premium charged and the actuarial value of any deductible, co-insurance or co-payment charged for additional services (described in the preceding paragraph) could not exceed the adjusted community rate for those services.

Third, the HMO must provide services to medicare beneficiaries through institutions' entities and persons meeting the applicable requirements of Sec. 1861 of the Social Security Act.

Fourth, in order to assure that an HMO makes a genuine effort to enroll medicare beneficiaries, the HMO must have an open enrollment period at least every year during which it accepts medicare beneficiaries up to the limits of its capacity and without restrictions in the order in which they apply for enrollment. This requirement is necessary since most HMO's enroll only groups and medicare beneficiaries, in many instances, would be enrolling as individuals; without assurance of open enrollment, such medicare beneficiaries would have no access to the HMO. No HMO, however, would have to accept proportionately more medicare enrollees than are represented in the population in the geographic area served by the HMO.

Fifth, the HMO must (1) provide assurances to the Secretary that it will not expell or refuse to re-enroll any medicare individual because of that individual's health status or requirement for health care services, and (2) notify each medicare beneficiary of such fact at the time of the individual's enrollment.

Six, the HMO must make its services available and accessible to medicare beneficiaries within the area served by the HMO promptly and in a manner which assures continuity. When medically necessary, those services must be available and accessible 24 hours a day and seven days a week. The HMO must also reimburse a medicare beneficiary if he or she paid for medically necessary and immediately required health care services rendered outside the HMO's service area.

Seventh, the HMO must provide meaningful procedures for hearing and resolving grievances between the HMO (including any entity or individual through which it provides its health services) and medicare beneficiaries.

And eighth, the HMO must have arrangements, established in accordance with regulations of the Secretary, for an on-going quality assurance program for health care services it provides to medicare beneficiaries.

Because federally qualified HMO's and other HMO's will participate in this medicare program, the committee intends for the Office of Health Maintenance Organizations in the Department of Health and Human Services to play a major role in determining whether an organization seeking participation under this provision meets the HMO definition and complies with the conditions of participation. Since many of the conditions of participation are similar to requirements for federally qualified HMO's, those conditions should be inter-

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preted consistently with the requirements of Title XXIII of the Public Health Service Act.

Federally qualified HMO's must set their premiums under a "community rating system" which is defined in Section 1302 (8) of the Public Health Service Act. Because the Committee expands the definition of HMO's to include organizations not federally qualified, the Committee's bill permits an HMO to develop an adjusted community rate for its medicare beneficiaries based upon its weighted aggregate premium for non-medicare beneficiaries. The adjustment of the weighted aggregate premium would be made in a manner similar to the adjustment of the community rate of a federally qualified HMO.

To insure that non-federally qualified HMO's which meet the definition of the Committee's bill disclose their ownership and related information in accordance with section 1124 of thhe Social Security Act, the Committee's bill modifies the definition of HMO's in Section 1124 so that it includes HMO's as defined in the Committee's bill.

During the Committee's deliberation some concern was expressed that HMO's will unduly benefit from participation in this program. It is the Committee's view that HMO's will benefit because this new system of reimbursement for medicare beneficiaries is consistent with their mode of operation for their other enrollees. An HMO will be paid an amount equal to 95 percent of the cost of providing medicare benefits to beneficiaries in its area, but the HMO will retain only that portion of the amount equal to its adjusted community rate. The difference will be returned to its medicare beneficiaries. An HMO will be required to conduct an open enrollment period during which it must accept medicare beneficiaries in the order in which they apply for enrollment. Because medicare beneficiaries are older they require considerably more health services; so an HMO will be assuming substantial financial risk during this open enrollment period.

Concerns were also expressed to the Committee that because nonfederally qualified HMO's will be permitted to participate medicare beneficiaries will be subjected to significant abuses by unregulated HMO's. The Committee also believes that this concern is unfounded. If a medicare beneficiary believes that he or she has received inadequate services or determines that he or she does not want to continue enrollment for any reason, they may terminate enrollment with one months notice. In addition, an HMO's medicare and medicaid enrollment cannot exceed 50 percent of its total enrollment. This provision, more than any other, will assure that participating HMO's are stable, well managed community businesses. If they do not satisfy the health care needs of their non-medicare enrollees, so that they disenroll and their number decline below one-half of the total enrollment, the HMO cannot continue participating in this medicare program.

The Committee's bill also amends Section 1122 of the Social Security Act. That section provides for review of capital expenditures made by or on behalf of a health care facility which is reimbursed under the Social Security Act. Under the current provisions of Section 1122 capital expenditures to be made by an HMO for the development of a health care facility would be reviewed. In the Health Planning and Resources Development Amendments of 1979, Public Law 96–79, the Congress determined that certain capital expenditures made by HMO's

should not be covered by state certificate of need programs. (These programs are required by Title XV of the Public Health Service Act.) The Committee believes that review under Section 1122 and under Title XV should be consistent. The Committee's amendment would modify Section 1122 to exclude from review a capital expenditure made by or on behalf of a health care facility if the obligation of the expenditure would not be required to be reviewed under Section 1527 of the Public Health Service Act.

This amendment does not impose any new requirement for review under Section 1122. For services which are not required by Title XV to be included in a state certificate of need program, such as home health services, those services would only be reviewed under Section 1122 if the section provided for such review.

QUALITY ASSURANCE PROGRAMS FOR CLINICAL LABORATORIES (SECTION 25)

The Committee bill extends to December 31, 1980, the Secretary's authority to conduct a program to determine the proficiency of health care personnel, including clinical laboratory personnel, who do not meet formal educational requirements.

The bill directs the Secretary to the extent feasible, to employ quality assurance methods which take into account the different tyupes of laboratories, and which impose the fewest restrictions on personnel who perform and supervise laboratory tests that are consistent with assuring adequate standards of quality. The Secretary's authority to impose requirements beyond those contained in existing requirements is limited to that found necessary to correct deficiencies in the quality of lab services. The Secretary is directed to assure that quality assurance standards adopted result in the least imposition of costs sufficient to attain the necessary quality, and to report periodically to the Congress on actions taken to assure quality in laboratories and on their effectiveness in accomplishing the purposes of this section.

Under current law, the Secretary is responsible for assuring the quality of diagnostic tests performed in hospital and independent laboratories for which reimbursement is sought under Medicare and Medicaid. The Committee is concerned that regulations recently proposed by the Secretary may be unduly burdensome to the laboratories affected. Accordingly, the Committee's bill would require that, in exercising her regulatory authority to assure that laboratory services provided to medicare and medicaid beneficiaries are of high quality, the Secretary shall only impose requirements found to be necessary to correct deficiencies in the quality of particular types of tests or laboratories. It is not the intent of the Committee that quality deficiencies must be proved to be generally prevalent or be identified in a specific laboratory before quality assurance standards could be applied. However, it is intended that the Secretary should have substantial evidence that quality assurance is needed in regard to a given type of test, or in the operation of a certain type of laboratory, before further standards are imposed. In other words, there should be some indication of a potential problem before further requirements are added. The bill also directs that, to the extent feasible, the Secretary employ quality assurance methods which take into account and are appropriate to the

different types of laboratories to which they apply. Such methods must be consistent with adequate standards of quality assurance and be designed to result in the least imposition of costs and the fewest restrictions on personnel performing or supervising laboratory tests consistent with assuring what the Secretary determines to be an appropriate level of quality. In making this determination, the Congress would encourage the Secretary to seek advice and recommendations as to the most cost-effective and least disruptive regulatory actions to achieve necessary standards of quality from a broadly based constituency of knowledgeable health professionals and other interested parties prior to the issuance of proposed regulations.

It should be stressed that the primary goal in regulation of laboratories is to assure adequate quality. The Committee does not intend to remove the Secretary's authority to establish further standards, including standards for personnel, if she determines that this must be done to assure appropriate quality of laboratory tests. But the Committee bill does instruct the Secretary to take cost into account, to adopt the least burdensome and least costly way to achieve the quality goal if alternatives are available, and to minimize the additional personnel standards when it is possible to do so and still achieve the appropriate result.

The intent of the Committee's bill is to guide the future exercise of discretion by the Secretary under current authority. The bill is not to be construed to require the Secretary to modify or repeal any regulations in effect as of January 1, 1980.

The Committee believes that proficiency examinations represent an effective mechanism for identifying competent health personnel who may lack the necessary credentials otherwise required under personnel standards contained in medicare's conditions of participation. Consequently, the bill extends the Secretary's authority to conduct such examinations to December 31, 1980.

REIMBURSEMENT OF CLINICAL LABORATORIES UNDER MEDICARE AND MEDICAID (SECTION 26)

The Committee bill places limitations on reimbursement for markups on clinical laboratory services billed by physicians under medicare and medicaid and authorizes State medicaid agencies, on a demonstration basis, to purchase laboratory services through a competitive bidding proces. The bill further directs the Secretary to evaluate and report to Congress on the impact of these policy changes. The bill also clarifies the requirement that all clinical laboratories furnishing services for which payment is claimed under medicaid must meet the medicare standards for participation.

Under current law, the medicare and medicaid programs may make payment for clinical laboratory services to hospitals, to physicians, or directly to independent laboratories; medicare can also make payments directly to patients. When the payment is to the physician, it may be for a test performed in his office, or it may be for a test which he sent out to an independent laboratory, which then billed the physician for the work. There is evidence, documented in GAO reports, that in some cases, the physician bills the patient (or the medicare or medi-

caid programs) for the test that was performed by the independent laboratory at rates greatly in excess of what the laboratory charged the physician for the work.

The committee bill addresses this problem of substantial markups of bills for laboratory services where the bill is submitted by the physician but the laboratory services are not performed by him. The bill provides that when a physician includes an amount in his bill for laboratory services, he must indicate either (i) that he or another physician in his office personally performed or supervised the laboratory services, or (ii) the name of the laboratory performing the services and the amount the physician was billed by the laboratory.

If the physician fails to provide the necessary information, the payment allowed for the laboratory services included in his bill will be limited to the charge estimated by the medicare carrier to be the lowest charge at which the services could have been secured by a physician from a laboratory serving the applicable locality. This provision is designed to serve as an incentive to the physician to provide the necessary information on laboratory services included in his bill, so that it can be determined that the laboratory doing the work is one that meets appropriate standards, and so that the program administrators can be certain that there is no unreasonable markup in the charge. Under current program requirements, physicians are required to provide similar information, but often do not. Medicare carriers find it impossible to follow up on all bills where the information is not included. This provision will provide authority to limit payments in these situations.

If the physician does indicate on his bill that the laboratory service was performed elsewhere, and indicates which laboratory performed the service and how much they billed him, the allowed payment will be the lower of that laboratory's reasonable charge (subject to the usual requirements of the law for determining reasonable charge) or the amount actually billed the physician, plus a nominal fee to cover the physician's costs in collecting and handling the sample. The Committee intends this fee be limited to the minimum amount generally necessary to cover physicians' actual costs of collecting and handling samples on which tests are performed.

The Committee expects this provision to result in lower program payments in many instances, because it is not uncommon for a laboratory to bill a physician less than its reasonable charges. This provision will assure that the programs will benefit from the discounted rate.

If the physician's bill indicates the laboratory service was performed by the physician or another physician with whom he shares his practice, or by someone under their supervision, the reimbursement allowed would be the physician's reasonable charge for that service (again, subject to the applicable provisions of the law regarding reasonable charge). The committee notes that use of the phrases "supervised the performance of such services" or "supervised such services" would not require that a physician personally supervise the performance of each test for which a bill has been submitted. The physician would be expected to exercise general supervisory responsibility. (In all cases, the amounts reimbursable under medicare are subject to applicable deductible and coinsurance requirements).

While the committee has determined that these limitations on payments for laboratory services are appropriate, there is concern that the reduction in reimbursements may fall on the patient rather than on the physician who fails to provide the required information on the laboratory services or who is engaging in excessive markups. The structure of the medicare program, under which many physicians do not take assignment and bill the program directly, results in many patients paying the physicians' fees and then submitting the bill to medicare. In this situation, there is a potential for the patient rather than the physician to feel the effect of the medicare policy to limit payments for laboratory services. The committee has determined that there cannot be justification for continuing a policy of paying excessive markups on laboratory tests because the failure of physicians to take assignment might result in the lower reimbursement going to the patient rather than the physician. However, the committee has directed the Secretary of HEW to report to the Congress within 2 years on the experience with this provision, particularly in regard to how frequently the reduction in the allowed amount has resulted in lower payments to the patient rather than to the physician. This information will allow determination of whether further legislative change to protect the patient is necessary. Additionally, the Secretary is required to report on the savings in expenditures for laboratory services which have resulted from this provision.

Under the medicaid program, a State has the authority to require that all bills for laboratory services be submitted directly by the practitioner or entity performing the service. The committee's bill leaves that option to the States; however, if a State opts instead to allow indirect billing, it is required to assure that reimbursement does not exceed the amount that would be allowed under medicare. To assure this, a State would have to require the physician to submit information essentially similar to the information required by medicare.

Under current medicaid law, program eligibles are entitled to obtain covered services from the provider of their choice. This freedom of choice requirement poses a bar to State or local efforts to limit the number of clinical laboratory service providers participating in medicaid through a competitive bidding process. The committee has concluded that the freedom-of-choice concept has little real applicability in the case of laboratory services where the patient, in fact, does not "choose" his provider in any real sense. Further, the committee notes that GAO has found that, even though medicaid programs are high volume purchasers of clinical laboratory services, State often pay higher prices for such services than other purchasers. Based on these findings GAO recommended that competitive bidding for medicaid laboratory services be tried on an experimental basis.

The Committee bill allows States (or parts thereof) to purchase laboratory services for a 3-year period under arrangements which would not be subject to the general freedom of choice requirements of the medicaid law, provided that the Secretary of Health, Education, and Welfare approved the plan. The Secretary would determine that services would be purchased only from laboratories that met standards, and that the prices charged the program would not exceed the lowest amount charged to others for similar tests, or, if the purchasing ar-

rangements were agreed to on some unit price basis, that the aggregate expenditures would not exceed the aggregate expenditures that would have been anticipated if each test was charged at the lowest rate charged to others for that test. Additionally, the Secretary must be satisfied that under the arrangement adequate laboratory services would be available to the physicians and other providers treating medicaid patients; the committee has required that the Secretary may approve State plans only when these conditions are met.

The committee is concerned, however, that concentration of medicaid business in a small number of laboratories might prove detrimental to quality if the laboratory served only the medicaid population. The committee believes it would be beneficial to make arrangements for the purchase of services only with laboratories that provide services to both private and public patients. Providers of laboratory services to the general population have established fee schedules for their services and often have operational quality assurance mechanisms, thus providing the purchaser with a ready means of determining the lowest rate charged for quality services. The committee does not wish to take any action which would result in the development of a two-class system of health care in this country by allowing States to purchase laboratory services from providers whose only customer is medicaid. Experience has generally shown that the existence of a private clientele has a quality assurance effect on the services provided to public patients. Therefore, the committee has established as an additional condition for approval of a State plan for the purchase of laboratory services that no more than 75 percent of the laboratory's business may be with medicaid and medicare patients.

The committee recognizes that one result of this legislation will be a reduction in the number of providers from whom a State, or political subdivision, purchase laboratory services. Theoretically, it would be possible for a State or political subdivision, under this act to enter into arrangements with only one provider of laboratory services in an area (provided the condition of adequate available services was met). The committee's intent, however, is not to encourage such a monopolistic situation in any large health care delivery area. Obviously, in such an area it is more desirable to encourage the utilization of several providers. If only one provider is serving a very large population group, the State could become the "captive" of the provider and find it administratively difficult to switch to another provider should the first prove to be inadequate or to charge excessive rates. In addition, accessibility of the services to the physician should be a consideration in determining the number of such arrangements. Therefore, it is the committee's expectation that States making arrangements with providers of laboratory services under this legislation would generally not make such arrangements with only one provider of such services in any large health care delivery area. Furthermore, the Secretary in establishing policies and rules to implement this provision should discourage such monopolistic situations.

Although the committee is persuaded that an override of the freedom-of-choice provision of medicaid is justified in the case of laboratory services, it recognizes that unanticipated problems may result when this policy is implemented. Consequently, the committee has lim-

ited the time period during which States may purchase laboratory services through these arrangements to 3 years, and has instructed the Secretary of HEW to evaluate experience with the new arrangements, and report to the Congress within 24 months on the results so that determination of whether the policy change should be permanent can be made.

Finally, the Committee bill clarifies the legislative authority for the current requirement in regulation that medicaid laboratories must meet the same standards required for laboratories participating in the Medicare program.

REIMBURSEMENT OF PHYSICIANS' SERVICES IN TEACHING HOSPITALS (SECTION 27)

The bill authorizes reimbursement under Medicare and Medicaid to hospitals with approved teaching programs for services rendered by physicians if the hospital so elects and if all physicians agree not to bill program eligibles for professional services rendered in the hospital; otherwise, physicians in teaching hospitals would be eligible for reimbursement directly under the physician payment provisions of Medicare and Medicaid. The bill also repeals certain provisions of 1972 amendments to the Social Security Act relating to payment of teaching physicians that were never implemented through regulation.

The medicare program, Title XVIII of the Social Security Act, is comprised of two complementary programs—the Hospital Insurance program which generally pays for institutionally provided services, such as hospital care, and the Supplementary Medical Insurance program which pays for physician, diagnostic, and ambulatory services. This structure raised several administrative questions when applied to the nation's teaching hospitals where the physicians provide both professional medical services to individual patients and educational and supervisory services to the hospital itself. Essentially, the bipartite structure of the medicare program necessitated that the dual activities of these teaching physicians be clearly separated for reimbursement purposes between the Hospital Insurance and Supplementary Medical Insurance components of medicare. In the early years of the medicare program, this separation was not effectively accomplished in some teaching hospitals.

The Social Security Amendments of 1972 (Public Law 92–603) included a provision (section 227) which was intended to assure that medicare would make charge reimbursement for physician services furnished in teaching hospitals only if its beneficiaries received bona fide private patient care. This was believed to be necessary because the General Accounting Office and other investigators found that some teaching physicians billed for services actually furnished by interns or residents who assumed responsibility for the treatment; in other cases, physicians' charges were out of proportion to the physician services actually rendered or the charges billed to other patients. Section 227 generally treated physician services furnished in teaching hospitals as hospital services, reimbursable to the hospital on the basis of reasonable costs. However, two exceptions were permitted to this general rule: Charges were payable for physician services furnished

in certain hospitals which had traditionally billed and collected for physician services on a charge basis; charges were also payable if a hospital's patients were private patients, with "private patient" to be defined in regulations by the Secretary. Implementation was scheduled for hospital cost reporting periods beginning after June 30, 1973.

However, to date, implementation has not occurred. Initially, section 15 of Public Law 93–233 delayed implementation so that the Institute of Medicine of the National Academy of Sciences could study and report on reasonable and equitable methods of reimbursing for physician services in teaching hospitals. (Section 15 also provided that hospitals could elect cost reimbursement for their physicians' services if all the physicians in the hospital agreed not to bill charges for services furnished to medicare patients. A small number of teaching hospitals have elected to be paid for physician services on this cost basis.) The Institute of Medicine study was issued in March 1976. The changes proposed by section 227 were to have taken effect on October 1, 1978. However, the Secretary has still not issued a notice of proposed rulemaking to implement the section 227 changes.

The Committee believes that no purpose would be served by further postponement of the effective date. The current situation results in uncertainty for providers and physicians concerning what the standards for reimbursement will be. Further, the Committee has reluctantly concluded that the current provision is apparently unadministrable. Additionally, the committee believes that there have been significant changes in the way services are furnished in teaching hospitals since enactment of section 227. Intermediary Letter No. 372, issued in April of 1969, established clearer criteria for identifying the personal, identifiable services a teaching physician must perform for an individual patient to qualify for a fee-for-service payment under the Supplementary Medical Insurance component of medicare. When these criteria are not met and properly documented in the medical record, it is presumed that the physician is provided only educational or supervisory services, and the costs of the service are included in the reimbursement from the hospital component of medicare. The patient care requirements of Intermediary Letter No. 372 seem to have been accepted by teaching physicians and adopted as policy by teaching hospitals.

The Committee bill, therefore, would permit physicians to continue to be reimbursed on a charge basis, unless the teaching hospital and all its physicians elect to be paid on the basis of reasonable cost (as previously permitted by section 15 of Public Law 93–233 on an interim basis), with the understanding that as a minimum the guidelines currently in effect governing payment for physicians' services in teaching hospitals, which this Committee endorses, will remain in effect. Further, this Committee expects that HEW will take steps forthwith to incorporate these guidelines in its regulations. Physicians, teaching hospitals, and related entities should recognize that the Committee's action is not an invitation to return to any abuses of the late sixties. The Committee strongly believes teaching physicians should personally perform or personally supervise patient services in order to qualify for fee-for-service payment. The Committee notes that failure of a physician, teaching hospital, or related entity to comply with these

requirements would, among other things, constitute a false statement or representation of a material fact in an application of payment under medicaid or medicare. The Committee expects the Department and State Medicaid fraud and abuse control units to vigorously pursue any noncompliance.

Where States elect to compensate for services of teaching or supervising physicians under medicaid, Federal matching should be limited to payments not in excess of medicare allowances.

The provision would be effective with cost reporting periods beginning on or after October 1, 1978.

REIMBURSEMENT UNDER MEDICAID FOR SERVICES FURNISHED BY NURSE MIDWIVES (SECTION 28)

The Committee bill requires States to provide coverage under their medicaid programs for services furnished by a nurse-midwife to the extent that he or she is authorized to perform such services under State law or regulation. The bill would authorize reimbursement on either an indirect or direct basis and would empower the Secretary to establish standards for nurse-midwife participation in medicaid.

Under current law, States may, at their option, provide coverage under their medicaid programs for nurse midwife services. They may recognize these services as within the scope of physicians' services, clinic services, or hospital services; in this case, payment is made to the physician, clinic, or hospital for which the nurse midwife is employed or otherwise associated. States also have the option of paying for these services by directly reimbursing the nurse-midwife who furnished them; the Committee is informed that only two States currently reimburse directly. In addition, medicaid law requires States to cover rural health clinic services, which include care provided by a licensed nurse midwife employed by, or receiving compensation from, a qualified rural health clinic (reimbursement is made to the clinic).

Nurse midwives are registered nurses with additional educational and clinical backgrounds in midwifery. Within the scope of their authority under State law or regulation, nurse midwives manage the care of normal mothers and newborn babies throughout the maternity cycle—pregnancy, labor, birth, and the immediate post-partum period—with various arrangements for physician referral and consultation in the event of complications. The Committee is informed that all but 3 States have laws or regulations authorizing or permitting the practice of midwifery.

The Committee heard testimony that nurse-midwives represent a cost-effective source of quality maternity care. In order to increase the availability and accessibility of nurse-midwives to low-income women eligible for medicaid, the Committee's bill requires States to provide coverage for nurse-midwife services to the extent that the nurse midwife is authorized to practice under State law. Reimbursement would be available whether or not the nurse midwife was under the supervision of, or associated with, a physician or other health care provider. It should be stressed again, however, that the Committee's bill would not preempt State law or regulation relating to the legality or scope of practice of nurse-midwives.

The Committee notes that as a result of making coverage of the services of a nurse midwife mandatory in the medicaid program, States would be required to offer direct reimbursement to these health care practitioners as one of the available payment options. As is generally the case under the medicaid program, each State would establish its own reimbursement level for these services, subject to the test of current law that reimbursement be sufficient to assure that the service is actually available (where there are nurse midwives).

In order to qualify as a nurse-midwife for purpose of receiving medicaid reimbursement, a registered nurse would either have to be certified by an organization recognized by the Secretary or have successfully completed a program of study and clinical experience that has been approved by the Secretary. In implementing these requirements, the Secretary is expected to provide for the establishment of standards that will assure that medicaid eligibles will receive high quality care without creating unnecessary barriers to entry for qualified nurse midwives seeking to participate in medicaid.

EXTENDED MEDICAID COVERAGE FOR THE SEVERELY MEDICALLY IMPAIRED (SECTION 29)

The committee bill changes current law treatment of those SSI recipients who are already eligible for medicaid and who have disabilities which are sufficiently severe to result in functional limitations requiring medical assistance in order that they may work. With respect to these individuals, states would be required to continue making medicaid coverage available even after the loss of SSI assistance due to work if (1) the loss of medicaid eligibility would seriously inhibit the individual's ability to continue employment and (2) the individual's earning are not sufficient to allow him or her to obtain medical coverage equivalent to that available under medicaid.

The bill also requires States with "medically needy" programs to apply certain income disregards in making medicaid eligibility determinations for the severely medically impaired to reflect work expenses related to the impairment.

Under current law, disabled persons who meet applicable assets and resource tests are eligible for cash assistance under the SSI program. States have the option of making medicaid coverage available to all SSI recipients or of limiting medicaid eligibility to those SSI recipients who meet the State's more restrictive income, assets, or other eligibility tests. All but 15 jurisdictions have opted to make medicaid coverage available to all SSI recipients. If a State does not provide medicaid to all persons receiving SSI, it must permit applicants for medical assistance to "spend down" into eligibility by applying medical expenses incurred against available income.

In order to qualify as disabled under current law for purposes of eligibility for SSI and medicaid, an individual must be unable to engage in any substantial gainful activity due to a medically determinable physical or mental impairment. Substantial gainful activity is currently defined as a level of earnings of $300 per month. Thus, a disabled SSI recipient who returns to work and earns more than $300 is no longer considered disabled; after a trial work period during which he or she continues to receive benefits, the individual loses medicaid

coverage as well as SSI benefits. Because cost of meeting the medical needs, attendant care expenses, and basic living costs of severely medically impaired individuals often exceeds the $300 level of earnings, the prospect of an abrupt termination of benefits keeps many disabled individuals with employment potential from seeking and accepting work.

The Committee is deeply concerned that the strong work disincentives in current law impose great hardships on severly medically disabled persons with a desire for independence and self-sufficiency through work. The potential loss of basic hospital, medical, and (in some States) personal care services available under Medicaid can have large deterrent effect on the ability of a disabled person to return to work with a continuing handicap.

Under the Committee's bill, States would be required to continue to provide medicaid coverage to SSI receipients with severe medical disabilities who, as a result of earnings, lose their SSI benefits and would not be able to continue working without medicaid coverage. For such an individual, provided he or she continued to meet all other applicable eligibility requirements, medicaid coverage would continue so long as (1) termination of benefits would seriously inhibit the indvidual's ability to continue employment and (2) the individual's earnings are not sufficient to provide a reasonable equivalent of the medicaid benefits.

The Committee intends that these determinations be made (in accordance with standards established by the Secretary through regulation), by the same State agencies that now make comparable determinations under current law. For example, where a State Rehabilitation Agency now administers both the disability and financial tests for such individuals, the Committee would expect such arrangements to continue: Where a State Rehabilitation Agency administers only the disability determinations and the single State medicaid agency administers the financial tests, the State could maintain such arrangements.

The continuation of medicaid benefits provided for under the bill would apply only to individuals with severe medical disabilities. In order to qualify as a severe medical disability, the individual's impairment must be sufficiently severe to result in a functional limitation requiring medical assistance in order to work. The Committee intends that in making this determination, the Secretary and the State Agencies shall apply the Listing of Impairments set forth in regulations (currently found at Title 20 of the Code of Federal Regulations, Subpart P, Appendix 1).

Under the bill, individuals determined to have severe medical disabilities who lose their SSI benefits would continue to be eligible for medicaid so long as this coverage was necessary to enable the individual to work. If termination of medicaid eligibility would seriously inhibit the individual's ability to continue employment, and if the individual's earnings are not sufficient to allow the individual to provide or secure a reasonable equivalent of medicaid benefits, the individual would be entitled to continued medicaid coverage. In making these determinations, the Committee expects that the State agencies will fairly consider all relevant financial and motivational factors in

each individual case in light of the bill's purpose of providing assistance in order to enable such persons to work. Individuals adversely affected by such State Agency determination are to be afforded the same appeal rights as those available to other individuals receiving medicaid on the basis of disability under the State Title XIX plan.

The Committee intends that, in determining whether an individual's earnings are sufficient to offset the loss of medicaid coverage, the State agency will carefully examine whether the individual will be able to purchase needed medical services in the absence of medicaid coverage. The Committee does not intend that such an individual be required to reduce income, net of medical expenses, below the applicable official poverty guideline employed by the Community Services Administration. The Committee expects the Secretary, through regulations, to establish standards or criteria for the guidance of State agency personnel (and affected individuals) in determining whether an individual's income is sufficient actually to obtain a reasonable equivalent of medicaid benefits. The Committee intends that these standards, to the extent feasible, will accurately reflect all relevant factors, including levels of income, degrees of disability, and differences in relevant medical expenses within each State and between urban and rural areas. In establishing such standards, the Secretary may determine that it is appropriate to establish a simplified standard to assist States to make a determination of presumptive eligibility, with application of the more detailed standards required only in cases where the presumptive standard is not met. The standards or criteria should be periodically reviewed and adjusted to reflect the impact of inflation on the medical purchasing power of such disabled individuals. The Committee intends that these guidelines be applied so as to expedite these individual determinations and to promote similar treatment of similarly situated individuals.

The bill further provides that, in making determinations as to whether an individual with severe medical disabilities is eligible for benefits under a State's medically needy program, the State must disregard certain impairment-related work expenses. These are: (1) 20 percent of the individual's gross earned income (representing expenses attributable to earning of such income); (2) any amounts necessary to pay the costs to the individual of attendant care services, medical devices, equipment, prostheses, and similar items and services (excluding routine drugs or routine medical services unless such drugs or services are necessary for the control of the disabling condition) which are necessary in order for the individual to work (whether or not the assistance is also needed to enable the individual to carry out normal daily functions); and (3) one half of the individual's remaining earned income.

The Committee believes that the income eligibility standards for medically needy programs operated at State option should avoid requirements of reductions in net income that would discourage continued work by individuals who have impairments sufficiently severe to result in a functional limitation requiring assistance in order to work. The bill therefore requires that States, in making medically needy income eligibility determinations, take into account the work expenses related to the impairments of such individuals through the use of specified income disregards.

CONTINUING MEDICAID ELIGIBILITY FOR CERTAIN INDIVIDUALS BY DISREGARDING CERTAIN INVOLUNTARY INCREASES IN INCOME (SECTION 30)

Under the bill, any cost-of-living or annual, general increases received by medicaid beneficiaries in Social Security, Railroad Retirement, Civil Service Retirement, or Veterans' benefits would be disregarded for purposes of determining their eligibility for continuing medicaid coverage. This disregard would apply only to individuals who were eligible for medicaid on or after June 1, 1980, and who would lose their medicaid eligibility as a result of any such cost-of-living or annual increase.

Under current law, persons who receive cost-of-living or annual increases in Social Security benefits, Railroad Retirement benefits, Veterans' benefits, or Civil Service Retirement benefits must accept those increases as a condition of medicaid eligibility. Generally, any such increases are included in the incomes of these persons for determining whether they meet, or continue to meet, the applicable State medicaid income standards. When these increases are counted, a person may lose medicaid eligibility even though the increase in income almost certainly is not sufficient to replace the value of the lost medicaid coverage. In the Unemployment Compensation Amendments of 1976, Public Law 94–566, Congress provided protection against loss of medicaid for persons who were receiving both Social Security and Supplemental Security Income (SSI) cash benefits, but who lose their SSI eligibility as a result of a cost-of-living increase in Social Security benefits. However, this protection did not extend to persons who were not actually receiving SSI payments (residents of nursing homes, for example, or medically needy persons), or to persons who received annual or cost-of-living increases in Railroad Retirement, Veterans' or Civil Service benefits.

The Committee believes that congressionally mandated increases in Social Security, Railroad Retirement, Veterans', or Civil Service Retirement benefits should not inadvertently penalize the low-income beneficiaries of those programs by terminating their eligibility for medicaid. The purpose of these cost-of-living or annual increases is to enhance the ability of these indigent beneficiaries to meet their subsistence needs; by resulting in the loss of medicaid eligibility, however, these increases have precisely the opposite effect.

The Committee's bill would require that any cost-of-living or annual, general increases in Social Security, Railroad Retirement, Veterans', or Civil Serive Retirement benefits be disregarded in determining whether a person eligible for medicaid should continue to receive medicaid coverage. This disregard would apply to all persons eligible for medicaid on or after June 1, 1980, who would lose their medicaid eligibility as a result of an increase in benefits under one of these programs. It would apply to both categorically needy and medically needy eligibles in all participating jurisdictions.

The Committee does not intend that the disregard of increases specified by the bill be applied to persons establishing intial medicaid eligibility. Thus, a person who received a cost-of-living increase at some point after June 1, 1980, and had not, prior to that time, been receiving medicaid (or had not had a formal determination of eligi-

bility) would not be entitled to have the increase disregarded in determining eligibility. Once eligibility for medicaid has been established, however, a person receiving an annual or cost-of-living increase specified in the bill after that time would be entitled to have the full amount of such increase disregarded for medicaid eligibility purposes.

Under current law, persons may, at a State's option, establish eligibility for medicaid by "spending down." This applies in States that have opted to cover the medically needy and in States that have opted to impose their own more restrictive eligibility standards on SSI recipients for medicaid coverage. Under the "spend down" process, incurred medical expenses are deducted from countable income in determining eligibility for a specified time period. When that period ends, these persons must once again incur sufficient medical expenses to reduce their income below the State eligibility standard. Although the Committee intends that no medicaid recipient should lose eligibility or have the conditions of their coverage changed solely because of a general increase in benefit levels under the Federal programs cited, it is recognized that application of this principle is somewhat more difficult in the case of medicaid recipients who are eligible solely because of the deduction of incurred medical expenses from their income. Such recipients are usually eligible only for a specified time period. When that period ends, they are ineligible until they again incur sufficient medical expenses to reduce their income below the State's eligibility standard. For recipients eligible by virtue of the "spend-down", the Committee intends that they be allowed the disregard of annual Federal benefit increases for each eligibility period in a consecutive series of such periods, so long as they continue to become eligible (by incurring sufficient medical expenses) during each period. If they fail to become eligible during any period, they will be considered to have become "otherwise ineligible for assistance" and will not be entitled to the disregard if they apply for subsequent periods. They would be treated in a comparable manner to those individuals previously eligible without a spend-down who lose eligibility because their income, not including annual Federal benefit level increases, rises above the State's eligibility standard. The Committee believes that this approach will assure that no current recipient loses eligibility due to an annual Federal benefit increase, while not requiring States to maintain extensive records on previous benefit level increases for individuals who are not currently on the rolls.

The Committee expects that the Department will make arrangements with the agencies responsible for administering the Social Security, Railroad Retirement, Veterans, and Civil Service benefits programs specified by the bill whereby these agencies will provide, both on a periodic basis and on request, a statement of the amount of any cost-of-living or other general increase for each affected beneficiary, as well as the cumulative total of such increases after June 1, 1980. The Committee further intends that such arrangements will include adequate mechanisms for making such information available on a timely basis to beneficiaries and State medicaid agencies in order that eligibility determinations in such cases are expeditiously processed.

LIMITATION ON MEDICAID ELIGIBILITY FOR INDIVIDUALS WHO DISPOSE OF RESOURCES (SECTION 31)

The bill authorizes States to delay eligibility for medicaid coverage to certain individuals for specified periods of time (up to 24 months) if, within 2 years preceding application for medicaid coverage, an individual had disposed of resources with an uncompensated value of $6,000 or more in order to establish medicaid eligibility. The bill further authorizes States to recover medicaid payments made on behalf of individuals who disposed of assets to gain medicaid eligibility.

Under current law, States must make medicaid coverage available to recipients of aid to families with dependent children (AFDC). States have the option of making medicaid available to all aged, blind, and disabled persons who receive title XVI supplemental security income (SSI) or State supplemental benefits or of imposing their own more restrictive eligibility tests to determine whether SSI recipients qualify for medicaid. Any State that covers all title XVI beneficiaries under its medicaid program must use the same eligibility rules and procedures, except for the level of income and resources, in determining medicaid eligibility for other aged, blind, and disabled persons, including nursing home residents and the medically needy (those whose income or resources exceed the eligibility standards for SSI cash payments).

Under current SSI law, persons who dispose of assets (real or personal property, or cash) by sale or gift before filing an application for cash assistance benefits can qualify for SSI benefits even though retention of the assets would have made the applicant ineligible due to excess resources. Generally, such persons would, by establishing eligibility for SSI, become eligible for medicaid benefits as well (except in those States that apply their own more restrictive standards). Further, since there is no prohibition against transfer of assets in the SSI program under current law, a State which does not restrict eligibility of title XVI beneficiaries may not impose such a restriction on medicaid eligibility for any other aged, blind or disabled person.

(It should be noted that the House has passed as part of H.R. 4904, the Social Welfare Reform Amendments of 1979, a provision which would deny SSI eligibility for a specified period to persons who dispose of assets to gain eligibility; that has not yet been enacted, however, so current law continues to govern medicaid policy.)

The Committee is concerned that persons with substantial resources may be able to receive medicaid benefits by purposefully transferring their valuable assets in order to qualify for medicaid without receiving in fair exchange money that they could live on or goods and services relevant to their support. To the extent that such abuse of the medicaid program occurs, the Committee's bill would provide States with two differential authorities for addressing the problem.

Under the Committee bill, a State could delay eligibility for medicaid coverage for specified periods of time if, within 24 months before filing an application for medicaid benefits, an individual had disposed of resources at less than current market value for the purpose of estab-

lishing eligibility for such benefits and if the uncompensated value of the resources exceeded $6,000. The uncompensated value is the difference between the amount of compensation, if any, and the current market value of the person's equity interest in the resource. Because the intent of the Committee is not to penalize low income individuals with very limited resources, the bill does not authorize a State to deny or delay eligibility where the uncompensated value of the resource is less than $6,000.

The period of eligibility delay is related to the amount of uncompensated value. If the uncompensated value of the resource exceeds $6,000 but is less than $12,000, the bill authorizes a delay of 6 months; if the uncompensated value exceeds $12,000 but is less than $30,000, 12 months; and if the uncompensated value exceeds $30,000, 24 months. The delay in eligibility is to take effect beginning with the month following the transfer of the resource. The delay is to cease after the month in which the resources were returned to the transferor or the transferor receives compensation for the resources equal to the uncompensated value.

The Committee believes that no State should be authorized to impose medicaid transfer of resource prohibitions that are more restrictive than those provided for in the Committee's bill. Therefore, all States, including States which have opted not to cover all SSI recipients, would be subject to the requirement that any transfer of assets requirement applied as a condition of medicaid eligibility could not be more restrictive than the standard established in this bill.

It should be noted that under the Committee bill, restrictions on transfer of assets would not apply to individuals actually receiving SSI benefits except those residing in States that do not make medicaid coverage available to all SSI recipients. Until the SSI law is changed, SSI eligibility does not take into account assets an individual no longer has, whether or not they were transferred for the purpose of securing eligibility. The receipt of SSI automatically brings medicaid eligibility in most States. Where that occurs, it is the judgment of the Committee that the administrative complications which would be raised by denying medicaid to an SSI recipient outweigh the advantages of applying a transfer of assets provision for medicaid purposes to SSI recipients. Again, however, it should be noted that H.R. 4904, if enacted, would change SSI policy, and result in similar treatment for medicaid purposes of SSI recipients and nonrecipients alike.

The bill authorizes a State to presume that any disposition of resources within the 24 month period prior to an application for benefits has been for the purpose of obtaining medicaid coverage. However, before imposing any delay, a State must provide the individual written notice and an opportunity for a fair hearing under the State plan to rebut this presumption. If the individual is able to present clear and convincing evidence that the transfer was for some purpose other than establishing eligibility for medicaid benefits, the State shall not impose any delay. The Committee bill also authorizes the States to reduce the period of delay, or waive it altogether, in cases that the State determines that such relief is justified, even though the presumption of improper transfer has not been rebutted.

The Committee heard testimony that individuals have, on the basis of self-serving advice, transferred resources to others at less than cur-

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rent market value yet are unable to recover those resources or their uncompensated value. The Committee does not intend that States penalize individuals that have been subject to such exploitation by delaying their eligibility for medicaid.

Under the Committee bill, the State would also be authorized to recover from the person to whom resources were transferred at less than current market value part or all of the State's medicaid outlays on behalf of the person who transferred the resources. The Committee believes that a State, rather than delaying the eligibility of a person who transfers substantial assets in order to qualify for medicaid and perhaps denying that person needed medical care, may prefer to proceed against the transferee to recover the costs of whatever medical assistance was provided. A State may choose both to delay the eligibility of the transferor and to recover from the transferee.

The Committee intends that a State, in exercising its authority under this provisions of the bill, would utilize appropriate State judicial procedures to assure due process to a transferee. Under the bill no State could initiate an action for recovery more than 3 years after the end of a period of ineligibility of the transferor. This assures that a transferee's potential liability is not indefinite. Since it would be unfair to hold the transferee responsible for more than the uncompensated value of the asset improperly transferred, the bill limits the State's right of recovery to the lesser of the uncompensated value or the cost of the medical assistance provided to the transferor during or after the period the transferor was (or could have been) determined to be ineligible.

This provision of the Committee's bill would apply to dispositions of resources occurring on or after the date of enactment.

ADJUSTMENT OF DOLLAR LIMITATION AND ELIMINATION OF SPECIAL LIMITATION ON MEDICAID PAYMENTS TO PUERTO RICO, THE VIRGIN ISLANDS, GUAM, THE NORTHERN MARIANA ISLANDS, AMERICAN SAMOA, AND THE TRUST TERRITORY OF THE PACIFIC ISLANDS (SECTION 32)

The bill increases the ceilings on Federal medicaid matching payments in fiscal year 1980 to Puerto Rico, Guam, and the Virgin Islands and provides for an adjustment in these ceilings in subsequent fiscal years by a percent equal to the percentage increase in the Consumer Price Index. Subject to these ceilings, the Federal medicaid matching rates in these jurisdictions would, under the bill, be determined on same basis as they are with respect to the States. The bill also authorizes participation in medicaid by the Northern Mariana Islands, American Samoa, and the Trust Territory of the Pacific Islands on the same basis (Federal matching payments subject to an annual ceiling with adjustments for inflation).

Under current medicaid law, the Federal Government shares with the States the cost of medical vendor payments according to a statutory formula, which is designed to provide a higher percentage of Federal matching payments to States with low per capita incomes. Whatever amount a State expends in vendor payments, the Federal Government will pay its share at the rate determined under the formula, ranging from a minimum of 50 percent to a maximum of 83 percent.

Although they participate in medicaid, Puerto Rico, the Virgin Islands, and Guam do not currently receive Federal matching funds on the same basis as the States. As originally enacted in 1965, title XIX of the Social Security Act (medicaid) had only one provision specifically relating to Guam, Puerto Rico, and the Virgin Islands. The Federal matching percentage was set at 55 percent rather than according to the per capita income formula used for the States, which would have resulted in substantially higher matching rates. This provision was related to comparable limitations under the then existing cash assistance programs. (When the cash assistance programs were amended to include the jurisdictions in 1949, lower matching and an overall limit on Federal funds were established).

As part of the Social Security Amendments of 1967, the provisions relating to the jurisdictions were changed:

(*a*) To exempt them from the limit on income levels for the medically needy. The 1967 amendments provided that in the States and the District of Columbia, the eligibility level for the medically needy could not exceed 133 percent of the highest amount paid to an AFDC family. The jurisdictions were exempted from this because of the extremely low levels of their cash assistance payments;

(*b*) To exempt them from the requirement that medicaid recipients have freedom of choice of providers. The large public health care systems existing in the jurisdictions made this requirement inappropriate;

(*c*) To reduce the Federal matching rate to 50 percent; and

(*d*) To establish ceilings on the amount of Federal matching funds available under title XIX.

In 1972, the ceilings on Federal payments under title XIX were increased from $20 million to $30 million for Puerto Rico, and from $650,000 to $1 million for the Virgin Islands. Payments to Guam have been limited to $900,000.

The original justifications for the limitation on Federal matching funds for the jurisdictions was based on their tax status. The Commonwealth of Puerto Rico has been exempt from Federal personal and corporate income taxes, and excise taxes have been rebated intact to the Commonwealth government. The Federal income tax laws apply to the territories, Guam, and the Virgin Islands; however, the Federal income tax revenues are rebated intact for the use of the territorial government.

However, residents of Puerto Rico, Guam and the Virgin Islands are U.S. citizens. Poverty retains serious dimensions in the jurisdictions. Inflation in the jurisdictions has been at rates substantially in excess of that experienced in the States. Unemployment is substantial.

Since the time that ceilings were last adjusted for the jurisdiction, inflation in the cost of medical care has been high. Hospital expenditures have increased so rapidly that they double approximately every 5 years. Over the last several years, the Medical Care Price Index has increased at rates close to 10 percent annually. The medicaid program itself has tripled since 1972. Yet the ceilings on Federal expenditures in the jurisdictions have been constant. Both in real dollar terms, and as proportions of Federal payments in the medicaid pro-

gram, these ceilings have in effect represented a substantial decline in Federal support for medicaid in Guam, Puerto Rico, and the Virgin Islands. The committee believes it is appropriate to reaffirm a commitment of support equivalent to that established in 1972.

Federal matching rate in each case is set at 50 percent and subject to a fixed dollar ceiling that does not change over time. As a result, these jurisdictions are forced to bear a disproportionately large portion of the increasing fiscal responsibility for providing health care to the disadvantaged.

With respect to each of these jurisdictions, the Committee's bill would eliminate the 50 percent limitation on the Federal medicaid matching rate and raise the annual ceilings to which federal payments would be subject. In the case of Puerto Rico, the ceiling for fiscal year 1980 would be raised from $30 million to $60 million; in the case of the Virgin Islands, from $1 million to $2 million; and in the case of Guam, from $.9 million to $1.8 million. To assure that the federal contribution does not diminish over time due to inflation, the bill provides for an annual adjustment in these ceilings by a percent equal to the percentage increase in the CPI.

Public Law 94–241 authorized the participation of the Northern Marianas in medicaid. This bill places the authority for participation in the Social Security Act, and establishes a ceiling on Federal payments which would be available to assist in meeting the cost of their medicaid program at $250,000 in fiscal year 1980. The bill also authorizes participation in medicaid by American Samoa and the Trust Territory of the Pacific Islands, two areas which do not now have programs, and establishes ceilings on the Federal contribution of $800,000 in fiscal year 1980 for American Samoa and $1,800,000 for the Trust Territory of the Pacific Islands. These ceilings would also be adjusted annually by the rate of increase in the CPI.

EXTENSION OF INCREASED FUNDING FOR LONG TERM CARE FACILITY INSPECTORS UNDER MEDICAID (SECTION 33)

The bill would extend through fiscal year 1983 the current federal matching rate of 100 percent for the costs of State long-term care facility inspections.

Under current law, skilled nursing facilities (SNFs) and immediate care facilities (ICFs) participating in medicaid are required to meet staffing, licensing, life safety, and various other health and safety standards. To encourage States to devote adequate resources to the inspection of SNFs and ICFs and assure conformity with these requirements, the Federal Government now pays 100 percent of the costs of training and compensating personnel responsible for such inspections. This 100 percent matching rate for medicaid inspections is due to expire on September 30, 1980; thereafter, the Federal matching rate would drop to 75 percent, the rate which otherwise applies for State administrative costs involving skilled medical personnel, and the rate that was in effect for long-term care facility inspections prior to passage of the Social Security Amendments of 1972.

The Committee is concerned that, should the scheduled decrease in Federal matching payments take effect, some States might respond by

reducing personnel, thereby weakening their inspection and enforcement efforts and possibly jeopardizing the health and safety of program eligibles receiving long-term care in participating SNFs and ICFs. Accordingly, the Committee's bill would extend the current 100 percent matching rate for an additional 3 years. The Committee stresses that, in accepting this Federal financial assistance, States are subject to the provisions of Title VI of the Civil Rights Act of 1964 which, among other things, prohibit discrimination in connection with the employment of inspection personnel on the basis of race, color, or national origin. Additionally, the Committee notes its strong belief that the political affiliation of such personnel should not have bearing on employment; and to take this into account where Federal funds are supporting 100 percent of the costs of these personnel would be counter to the intent of the Committee in recommending this bill.

While some have urged that the 100 percent matching rate be extended on a permanent basis, the Committee has determined that a limited extension would be more appropriate at this time. The Committee is concerned that some of the State inspection programs may not be as effective as the Committee would expect in assuring safe conditions or quality care in participating SNFs and ICFs and may be excessively costly to the Federal government. It is the Committee's intention to request the Comptroller General to investigate the effectiveness of State inspection programs funded under this provision and to make recommendations to the Congress before any further extension in the 100 percent matching rate would be considered.

EXTENSION OF INCREASED FUNDING FOR STATE MEDICAID FRAUD CONTROL UNITS (SECTION 34)

The bill authorizes Federal matching payments to the States for the costs of establishing and operating medicaid fraud control units at the rate of 90 percent for an initial 3-year period and 75 percent thereafter. These payments would be subject to a ceiling of the higher of $125,000 or one-quarter of 1 percent of total medicaid outlays in the State in the previous quarter.

Under current law, Federal matching payments are available to States that establish agencies to investigate and prosecute fraud in their medicaid programs. To encourage the development of such medicaid fraud control units, Congress in 1977 provided that States would be reimbursed for 90 percent of the start-up and operating costs. This 90 percent matching rate was made available for only three years; it is scheduled to expire on September 30, 1980. Thereafter, the Federal matching payment will drop to 50 percent, the usual rate provided in the medicaid program for administrative costs.

The Committee is informed that some 28 States now have medicaid fraud control units in place and that another 13 States are in the process of developing such a capability. However, some of the States that wish to establish such units have experienced delays in doing so and, under current law, would not be able to realize the full benefit of the increased Federal matching rate. The Committee's bill would eliminate this artificial deadline and substitute a Federal matching arrangement of 90 percent for a 3-year period and 75 percent there-

after. Thus, regardless of when a State began to develop its medicaid fraud control unit, it would be eligible for up to 3 years of Federal funding at the 90 percent matching rate. It should be understood that this provision would not give States an additional three years of 90 percent Federal funding if they have already been receiving the higher matching payments; the total time a State could draw the 90 percent would be measured from enactment of the original provision. After three years of 90 percent funding, the rate would drop to 75 percent, a level designed to provide a continuing incentive for operation of these units. As under current law, Federal matching payments in any calendar quarter would be limited to the greater of $125,000 or 0.25 percent of the total medicaid outlays in the State for the previous quarter.

The Committee believes that expenditures to assure the development and continued operation of effective State fraud units constitute a highly effective use of Federal funds. The Inspector General has estimated that without a continuation of the higher Federal matching rate, some existing State fraud agencies would cease operation and other States now interested in establishing units would not do so. Although there is little question that most units are clearly cost effective, without the special Federal funding, there is a concern that bureaucratic pressures and inertia within a State might result in the medicaid agencies simply absorbing the anti-fraud activities into their already numerous functions, with a loss of effectiveness in criminal investigation and prosecution activities, for which the independent anti-fraud agencies are better suited.

MEDICAID PAYMENTS TO STATES (FUND DRAW DOWN) (SECTION 35)

The bill provides that States may not draw on Federal medicaid matching funds until these funds are actually needed to pay claims for payment from participating providers. The bill authorizes the Secretary, in implementing this requirement, to approve alternate procedures where indicated by administrative or State constitutional considerations.

Under current law, the Federal Government makes matching payments available to those States participating in medicaid for vendor payments and administrative costs. States commonly draw these Federal matching payments 2 or 3 days before they issue checks (or warrants) to participating providers who have submitted valid claims for payment. The States then have the use of the Federal funds, and the interest income thereon, during the 7 to 10 day period in which the checks are mailed to the providers, endorsed, and then cleared through the State depository for payment.

It is the belief of the Committee that the Federal Government should minimize the period that Federal funds lay in these interest bearing accounts. The Committee's bill directs the Secretary, in making medicaid matching funds available to the States, to insure that States do not draw down on these funds until the time that checks clear the State's depository for payment. The purpose of this change is to assure that, to the extent practicable, the control of Federal matching funds and the benefit of any income thereon remains with

the Federal Government until the States actually must make payment on checks presented by participating providers.

The Committee recognizes that immediate implementation of this new procedure, generally referred to as a "checks paid" letter of credit, may not be administratively feasible in all of the States. To give the Secretary and the States a measure of flexibility in implementing this new procedure, the bill authorizes the Secretary to approve State procedures for estimating their need to draw down on Federal funds on the basis of the actual patterns of clearance of checks or warrants issued to medicaid providers. The Committee intends that, in reviewing these alternative estimating procedures, which may include the "delay of drawdown" method, the Secretary shall give careful consideration to the cost-effectiveness of these methods and the extent to which they are consistent with the Federal government's interest in prudent management of its cash resources.

The Committee recognizes there is disparity among States in the accounting and payment systems used in writing checks for medicaid and other programs. The language of the bill is intended to be interpreted in such a way that reasonable flexibility would be retained to assure the implementation of this section without imposing additional burdens on the State, it is the Committee's intention that the Secretary employ one or more methods to accomplish the objective of this provision.

Again, the Committee stresses that the language should not be interpreted in any way that would significantly increase either the size of the administering agencies or the costs of running the agencies at the Federal, State or local levels. The goals of improved administration is to create economies not increase complexity and stimulate increased long-term costs.

It has been brought to the Committee's attention that a few States may be unable, under the terms of their constitutions in effect at this time, to implement either a "checks paid" letter of credit procedure or an alternative estimating method. Officials of certain States may be prohibited from issuing checks or warrants without sufficient funds in their depositories or treasuries to pay for them, for example, and in certain situations this could make it impossible to implement the system.

In those states which have constitutionally related restrictions on the methods of payments from state accounts which might be affected by this legislation, the Committee wants to make it clear that it does not intend that its actions should have consequences which would require disruptions of state constitutional dictates and related supportive rules. The Committee's bill provides that, where the Secretary determines that a State constitution has reasonably been construed to prohibit the issuance of checks or warrants by State officials unless there are funds in the State Treasury to pay for them, the Secretary shall continue to allow the State to draw down on Federal funds before the issuance of a check or a warrant, but shall recover the amount of interest accruing on the funds. The bill provides for a method of payments by States for the time Federal funds are idle but, nevertheless, in the possession of a State.

The amount of interest recoverable is to be determined each calendar quarter based on the average 90-day Treasury bill auction rates, less the reasonable cost of banking services. The use of the 90-day Treasury bill average auction rate provides an easily attainable objective measurement for calculating interest in the Federal money balances for a given program. Banking service costs would be used as an offset against the calculated interest and could be calculated at average service charge rates of the three largest States, which do use the "check paid" system.

It is intended that the Federal Government will bear its share of costs for issuing and redeeming checks or warrants whether such services are procured through commercial banking institutions or through state operated facilities. Such costs will then be offset against the amount of interest calculated on the Federal funds held by the states in the period of time before the time those funds clear the state depository for payment.

It is the Committee's intention that the Secretary be flexible in selecting the method or methods to be employed in determining, for any particular state, the amount of interest on Federal funds held by the state in the period of time before the time those funds clear the state depository for payment. Such method or methods does not have to be based on each individual check or warrant cleared through the State depository for payment but may be based on the average time required for state expenditures to clear the state depository and may include the use of statistical sampling techniques.

The Committee notes that HEW has indicated its intent to establish administratively a system similar to the one described in the Committee bill. Because the Committee has been concerned with delays that have occurred, and wishes to be sure the potential savings from this system are actually realized, it determined it was appropriate to mandate action in legislation. However, the itent is not to reduce the administrative flexibility that the Department and the States may determine is necessary to make the system workable and reasonable. Finally, the Committee notes its belief that the system should be extended to all public assistance programs.

CHANGE IN CALENDAR QUARTER FOR WHICH SATISFACTORY UTILIZATION REVIEW MUST BE SHOWN TO RECEIVE WAIVER OF MEDICAID REDUCTION (SECTION 36)

The bill prohibits the Secretary from assessing financial penalties against States for failures to meet the requirements of medicaid law regarding utilization review of long-term care services in institutional settings for periods before January 1, 1978.

Under current law, States must, as a condition of participation in medicaid, have an adequate program of control over the utilization of institutional services, including reviews of the necessity for the admission and continued stay. Failure to meet these requirements subjects a State to a one-third reduction in Federal matching payments for long-term stays in institutional settings.

In 1977, after years of inaction, the Secretary assessed penalties against a number of States under this provision. The severe and un-

anticipated impact on affected State medicaid programs led Congress, in Public Law 95–142, to allow the States additional time to bring themselves into full compliance with the utilization control program requirements and to waive penalties assessed for past periods against any State demonstrating full compliance by December 31, 1977.

For technical reasons, the State of Colorado is, under current law, still subject to retroactive penalties. Since the Committee believes the State has complied with the spirit of Public Law 95–142, the Committee's bill would direct the Secretary to waive any financial penalty assessed against a State with respect to periods before January 1, 1978, if the State is able to show to the Secretary's satisfaction that it was in compliance on or before December 31, 1978. The Committee emphasizes that this technical change is in no way to be viewed as a retrenchment or a lack of resolve on its commitment to effective utilization control and medical audit programs under medicaid. It fully expects and intends that Colorado and all other States participating in medicaid will take the necessary steps to remain in full compliance.

DEMONSTRATION PROJECTS FOR REQUIRING SECOND OPINIONS FOR CERTAIN ELECTIVE PROCEDURES UNDER MEDICARE AND MEDICAID (SECTION 37)

The Committee bill authorizes the Secretary to undertake, through grant or contract, demonstration projects to determine the cost-effectiveness and effect on the patient of mandating that medicare and medicaid beneficiaries obtain a second opinion with respect to certain elective surgical procedures before payment will be made for those services.

Under current law, persons eligible for benefits under medicare and medicaid are entitled to have payment made for medically necessary physicians' and hospital services, including medically necessary elective surgical procedures. If program eligibles voluntarily seek second opinions from another physician before undergoing elective surgery, reimbursement is made for those consultations, subject to applicable cost-sharing requirements.

The Committee believes that second opinion programs may be of great value in reducing unnecessary surgery, in reducing unnecessary expenditures (both by Government and consumers), and by enabling consumers of medical care to make better informed choices as to their own well-being.

In hearings held by the Committee's Oversight and Investigations Subcommittee in 1975, 1976, 1977, and 1978 (resulting in reports in 1976 and 1979) and in hearings held by the Health and Environment Subcommittee in 1979, Eugene McCarthy of Cornell Medical School has presented eight years of data and follow-up on both mandatory and voluntary second opinion programs. That data has indicated the potential worth of second opinion programs. The Oversight and Investigations Subcommittee has also had independent confirmation of McCarthy's results from Canadian and U.S. board certified surgeons acting as consultants to the Subcommittee on the subject of hysterectomies and tonsillectomies.

In order to determine the relative effect of a mandatory second opinion program rather than the voluntary program of current law,

the bill directs the Department of Health, Education and Welfare to fund at least seven 2-year demonstration projects. These demonstrations would examine the effects of requiring a second physician's opinion on the rate and cost of selected elective surgical procedures funded by the medicare and medicaid programs. The Secretary of HEW would request proposals from public or private entities (PSRO's, Medical Societies, state agencies, etc.) covering populations of sufficient size to provide statistically significant data. Submitted proposals would be considered according to criteria determined by the Secretary and would, as far as possible, include rural and urban populations and several economic strata.

Under the Committee bill, the Secretary may fund a project only if it includes satisfactory procedures for notifying both patients and physicians of the existence and requirements of the project and to the extent practicable for preventing the physician providing the second opinion from knowing the identity of the physician offering the original opinion. It is the intent of the Committee that the Secretary assure that payment will be made for the second opinion only if the physician providing that second opinion is independent of the first physician and has no financial arrangements with him or her. Further, the bill requires that individuals must be provided with a list of physicians who will provide written second opinions. The Committee believes the program should not be carried out in health manpower shortage areas where there would be an insufficient number of physicians to give second opinions or where requiring second opinions would worsen the problem of securing necessary medical services which are already in short supply.

Patients in the demonstration areas who participate in the project (see the requirement of informed consent in Section 38) would be required to have a second opinion before medicare or medicaid would pay for the surgical procedure. Medicare or medicaid would pay the full cost of this additional benefit. Medicare or medicaid reimbursement would be dependent on obtaining the second opinion and payment would be made for the surgical procedure according to regular program rules if the patient made the final decision to have surgery, whether or not the first and second opinions were not in agreement. A patient could obtain a third opinion, if he wished, when the first and second opinions did not concur. Emergency or urgent surgery would not require a second opinion.

An evaluative component would be built into the demonstration projects to provide statistically valid data on the following: (1) effect on number of procedures performed, (2) savings of items such as direct and indirect surgical costs, (3) additional medical costs incurred, (4) administrative costs, (5) administrative complexities of a required program, (6) health status of patients in relationship to whether or not they had a surgical procedure and (7) additional information obtained by the patient from a second physician's opinion. Existing data is insufficient to determine the effect of a mandatory second opinion program on these variables.

The number of patients receiving second surgical opinions under this type of program is expected to exceed those reached under a voluntary program thus providing data to evaluate the effect of the

second opinion program in terms of the criteria described above, when it is used by a large number of patients who are not self-selected.

APPLICATION OF INFORMED CONSENT TO CERTAIN DEMONSTRATION PROJECTS (SECTION 38)

The bill provides that no medicare or medicaid beneficiary may be required to participate in a demonstration project for requiring second opinions for certain elective surgery without his or her informed consent.

Under current law, research, development, and related activities funded by grant or contract through HEW that would place human subjects at risk are required to meet regulatory standards designed to assure the protection of those subjects. Among these protections is the requirement that the activity obtain the legally effective informed consent of an individual before involving him or her as a subject.

The Committee does not believe that the demonstration projects for requiring second opinions for certain elective surgery authorized by the bill would place medicare or medicaid beneficiaries at risk. However, the Committee does feel that medicare and medicaid beneficiaries should not be subject to such a demonstration project without their written and legally effective informed consent. The bill provides that, before payment for an elective surgery can be denied under a demonstration project for failure by the beneficiary to obtain a required second opinion, the beneficiary must have given, in writing, his or her informed consent to participate in the project.

Under the bill, informed consent must be knowingly and freely given by the individual (or his legally authorized representative), without undue inducement and without constraint or coercion in any form. In order for the consent to be informed, each individual must receive a fair explanation of the nature and purposes of the project, a description of the risks and benefits that can reasonably be expected from participation in the project, a disclosure of any appropriate alternatives to participation that might be advantageous to the individual, and an offer to answer any questions the individual might have with respect to the project.

The Committee notes that since the purpose of these projects is to determine the differential costs and effects of a program where the receipt of the second opinion is required before the elective surgery is paid for rather than something that may be done at the option of the individual when the initial opinion recommending surgery is received, the Secretary would be expected to receive some assurance in regard to a given project that sufficient numbers of persons would consent to participate (and agree to the requirement of a mandatory second opinion) before the project would be funded. The Committee would expect, then, that the consent would generally be sought prior to an occasion when the initial recommendation for surgery is made. However, once a sufficient level of participation is assured, at the option of the project and the Secretary, further participants could be allowed to enter the project if they are willing to give their informed consent to participate at the point when the recommendation for one of the elective surgical procedures is made.

CONTINUED USE OF DEMONSTRATION PROJECT REIMBURSEMENT SYSTEMS (SECTION 39)

The bill authorizes States with rate-setting programs for the payment for hospital services that have been approved as demonstration projects by the Secretary to continue to determine medicare and medicaid reimbursement rates for hospitals under those programs unless the Secretary finds that the program no longer meets applicable standards.

Under current law, hospitals participating in medicare and medicaid are generally reimbursed on a "reasonable cost" basis for covered inpatient services. The Secretary has the authority to approve the use of alternative reimbursement rates or methodologies in connection with demonstration projects to determine whether the alternatives will increase the efficiency and reduce the costs of providing hospital services under medicare and medicaid without adversely affecting the quality of services provided. Four major projects in Maryland, New York, New Jersey, and Washington are currently operating under this demonstration authority.

While the Secretary has authority to determine the appropriate length of a demonstration project sufficient to carry out the purposes of the demonstration, she does not have the authority to extend demonstration projects indefinitely. As a result, several States now operating approved programs are in jeopardy of losing their authority to determine medicare and medicaid rates for hospital services on other than a "reasonable cost" basis, even though the programs have effectively restrained the rates of increase in the costs of hospital services. The loss of this authority would have a severe and adverse impact on the ability of the affected States to carry out their hospital cost containment efforts and might lead to increased Federal medicare and medicaid outlays as well.

The Committee's bill authorizes the Secretary to continue to allow medicare and medicaid reimbursement to be made under a reimbursement system originally established on a demonstration project basis after the demonstration period has ended. The demonstration projects must have been approved by the Secretary under section 402 of the Social Security Amendments of 1967 as amended by Section 222(b) of the Social Security Amendments of 1972, or Section 222(a) of the Social Security Amendments of 1972, and the rate of increase in the costs per admission of medicare patients during the course of the project must have been less than or equal to the rate of increase for all medicare beneficiaries during that period. If these conditions are met, and if the State has legislative authority to operate such a system (and the State elects to have reimbursement made under the system) or the system is operated through a voluntary agreement of hospitals (and those hospitals elect reimbursement under the system), then the Secretary must continue to allow medicare and medicaid rates to be established through the rate-setting system.

Under the Committee's bill, use of the demonstration project reimbursement system would continue until the Secretary determines that all third party payers do not reimburse participating hospitals on the basis required under the system, or that the rate of increase in costs

per admission of medicare patients in the participating hospitals when measured over the previous three year period, exceeds the comparable rate of increase in costs per admission for medicare patients in all hospitals throughout the country. These limitations on the State's continuing authority are intended to insure that the medicare program does not pay more for hospital services under the State's system than under the "reasonable cost" payment method.

The Committee would expect the Secretary to develop a process for reviewing and validating the performance of the system, and for monitoring any changes in the plan. It is not the intent of the Committee to freeze the system in place in exactly the form approved as part of the demonstration if improvements can be made; however, it is the intent that the program would continue to operate in basically the same form so that the Secretary is assured that its effectiveness is not impaired, and that additional costs are not shifted to medicare or medicaid.

OTHER ISSUES

Surveys of Long-Term Care Facilities

The Committee notes that under present law and regulations skilled nursing facilities and intermediate care facilities must be recertified every 12 months. While we believe every facility's certification status should be reviewed annually, we do not believe annual recertification decisions necessarily must be based on a full survey of every facility as is current practice. The Committee notes that under the current law, the Secretary has the latitude to develop and implement, through regulations, standards for determining the extent and scope and surveys needed to support the annual recertification delision. Criteria for determining the extent of the survey needed might include the compliance history of a facility, the nature and frequency of any complaints against it, and other relevant factors set forth in regulations.

The Committee notes that over 30 percent of all skilled nursing facilities currently participating in both medicare and medicaid, for example, have been found to comply with all Federal standards. To continue the current practice of full annual surveys in these facilities drains limited survey resources that could otherwise be devoted to improving conditions in poor facilities. It also offers no incentive for facilities to achieve and maintain a high level of health and safety. The Committee notes that annual licensure surveys under State law would not be affected by any changes in current Federal practices.

Coverage of Podiatrists Under Medicaid

Under current law, the services of podiatrists are covered under the medicaid program at the option of the State; current information indicates that 36 States have opted to provide this coverage. On the other hand, coverage of physicians' services are mandated in all State medicaid programs.

Under the medicare program, the term physician is defined to include a doctor of podiatry or surgical chiropody with respect to functions he is qualified to perform under State law. However, the medicare program specifically excludes payment of expenses for treatment of flat foot conditions, treatment of subluxations of the foot, or

routine foot care. Thus, although the definition of a physician is broader than under medicaid, the coverage of services that would be provided by a podiatrist is considerably more limited than what could be covered at State option under the medicaid program.

The Committee believes it is appropriate to determine what the effects would be of including podiatrists within the definition of a physician for purposes of the medicaid program, both with and without the Title XVIII limitations regarding foot care services, in terms of costs and availability of services. The Committee is requesting that the Congressional Budget Office undertake a study of this issue so that the findings will be available to the Congress when future policy changes are considered.

III. Cost of Carrying Out the Bill

A. CONGRESSIONAL BUDGET OFFICE ESTIMATE

The following report with information relative to the costs of carrying out the bill was furnished to the Committee by the Congressional Budget Office:

U.S. Congress,
Congressional Budget Office,
Washington, D.C., March 28, 1980.

Hon. Harley O. Staggers,
Chairman, Committee on Interstate and Foreign Commerce, U.S. House of Representatives, Washington, D.C.

Dear Mr. Chairman: Pursuant to Section 403 of the Congressional Budget Act of 1974, the Congressional Budget Office has prepared the attached cost estimate for H.R. 4000, the Medicare and Medicaid Amendments of 1980.

Should the Committee so desire, we would be pleased to provide further details on the attached cost estimate.

Sincerely,

Alice M. Rivlin, *Director.*

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

March 28, 1980.

1. Bill number: H.R. 4000.
2. Bill title: Medicare and Medicaid Amendments of 1980.
3. Bill status: As ordered reported by the Committee on Interstate and Foreign Commerce on March 4, 1980.
4. Bill purpose: H.R. 4000 would amend titles XI, XVIII, and XIX of the Social Security Act primarily with respect to the medicare and medicaid programs. The bill would make numerous technical and administrative changes in these programs and in the professional standards review program. It would alter a variety of medicare and medicaid reimbursement procedures, modify the rules governing medicaid eligibility, require several studies and demonstration projects, and increase federal funding for medicaid programs in the territories.
5. Cost estimate:

[By fiscal years, in millions of dollars]

	1980	1981	1982	1983	1984	1985
A. DIRECT SPENDING PROVISIONS						
Medicare (function 550): Estimated outlays:						
Sec. 6: Required activities of PSRO's	0	(1)	(1)	(1)	(1)	(1)
Sec. 10: Study of PSRO criteria	(1)	(1)	0	0	0	0
Sec. 11: Nonprofit hospital philanthropy	0	70.0	70	80	90	100
Sec. 13: Study of SNF dual participation	(1)	(1)	0	0	0	0
Sec. 20: Hospitals providing long-term care services:						
Swing beds	0	2.0	10	17	19	20
Reimbursement for inappropriate hospital services	0	−48.0	−73	−83	−94	−107
Sec. 22: Voluntary certification of "medigap" policies	(1)	(1)	(1)	0	(1)	0
Sec. 24: Reimbursement for health maintenance organizations	0	1	5	25	35	40
Sec. 26: Reimbursement for clinical laboratory services:						
Reimbursement limits	0	−14.0	−21	−23	−25	−27
Sec. 37: Second opinion demonstration projects	0	(1)	1	(1)	0	0
Sec. 38: Informed consent in certain demonstration projects	0	(1)	(1)	(1)	0	0
Total, medicare estimated outlays	(1)	11.0	−8	16	25	26
B. AMOUNTS SUBJECT TO APPROPRIATION ACTION						
Medicaid (function 550):						
Required budget authority	32.9	68.9	70	87	109	134
Estimated outlays:						
Sec. 11: Nonprofit hospital philanthropy	0	11.0	11	12	14	15
Sec. 20: Hospitals providing long-term care services:						
Swing beds	0	1	6	9	10	11
Reimbursement for inappropriate hspital services	0	−13.0	−20	−23	−26	−30
Sec. 21: Coordinated audits	0	−4.0	−5	−6	−6	−7
Sec. 23: Demonstration projects for training AFDC recipients as home health aides	0	1.0	−1	−9	−13	−18
Sec. 26: Reimbursement for clinical laboratory services:						
Reimbursement limits	0	−5.0	−7	−8	−8	−9
Competitive bidding	0	−7.0	−11	−9	0	0
Sec. 28: Reimbursement for nurse-midwives	0	(1)	(1)	(1)	(1)	(1)
Sec. 29: Extended coverage for the severly disabled	0	(1)	3	5	8	11
Sec. 30: Continuing eligibility despite cost-of-living increases	1.0	11.0	27	49	75	104
Sec. 31: Disposal of assets	0	−3.0	−7	−11	−16	−19
Sec. 32: Increased matching for the territories	31.9	31.9	35	39	42	45
Sec. 33: Funding for long-term care facility inspectors	0	9 0	10	11	0	0
Sec. 34: Funding for fraud control units	0	15.0	15	15	16	17
Sec. 35: Medicaid payments to States	−39.0	34.0	0	0	0	0
Sec. 36: Satisfactory utilization review	0	8.0	0	0	0	0
Sec. 37: Second opinion demonstration projects	0	(1)	(1)	(1)	0	0
Total, medicaid estimated outlays	−6.1	89.9	56	74	96	120
Other health (function 550):						
Authorization level	0	7.0	0	0	0	0
Estimated outlays: Sec. 37: Second opinion demonstration projects	0	4.0	1	1	1	0
AFDC (function 600):						
Required budget authority	0	(1)	−1	−5	−6	−7
Estimated outlays: Sec 23: Demonstration projects for training AFDC recipients as home health aides	0	(1)	−1	−5	−6	−7
Summary of outlays impact:						
Direct spending	(1)	11.0	−8	16	25	26
Amounts subject to appropriation action	−6.1	93.9	56	70	91	113
Total, estimated outlays	−6.1	104.9	48	86	116	139

[1] Estimated costs or savings less than 500,000.

Portions of this bill would increase future federal liabilities through changes to existing entitlements. Other portions would reduce those liabilities. Increases would require subsequent appropriation action to provide the necessary budget authority for the affected programs. Decreases would permit such action to reduce that budget authority. The figures shown as "Required Budget Authority" represent estimates of the amounts of the required increases or permitted reductions in the levels of budget authority needed under current law.

6. Basis of estimate: This estimate assumes an enactment date of June 30, 1980. Unless otherwise noted below, implementation of the

provisions of H.R. 4000 is assumed to begin January 1, 1981—allowing six months for promulgating regulations. Most provisions, therefore, would not affect spending in fiscal year 1980, and their costs in fiscal year 1981 are for three quarters only.

Provisions of this bill estimated by CBO to have costs or savings under $0.5 million are not discussed below.

Section 11—Nonprofit hospital philanthropy

This section would require that philanthropic contributions to nonprofit hospitals not be deducted from operating costs in determining reimbursement under medicare, medicaid, and Title V programs. The provision would apply to both restricted and unrestricted gifts. Estimates made by the Office of Financial and Actuarial Analysis (OFAA) in the Health Care Financing Administration (HCFA) have been adjusted by CBO to reflect assumed implementation on January 1, 1981 with retroactive adjustments of payments to hospitals for the preceding six months.

Section 20—Hospital providers of long-term-care services ("swing-beds")

Section 20 has two parts. One would authorize agreements between the Department of Health and Human Services (HHS) and individual hospitals for the provision of skilled nursing facility (SNF) services in temporarily unoccupied hospital beds. The other would establish a special reimbursement rate for days of inpatient hospital care furnished to medicare beneficiaries who are hospitalized only because necessary long-term care services are unavailable.

Under the first part, a hospital must have been granted a certificate-of-need for provision of long-term care services in order to obtain an agreement with HHS to provide SNF services in temporarily unoccupied beds. The reimbursement rate for these "swing" beds would be the average payment for routine services in skilled nursing facilities in the state in which the hospital is located plus the reasonable cost of ancillary services provided by the hospital.

Under present law, long-term care may be furnished to medicare and medicaid patients in hospitals, but only if it is provided in a distinct part of the hospital where beds are reserved solely for long-term care. This requirement has effectively limited provision of inpatient long-term care to large hospitals. The intent of the proposed change is to enable small hospitals to provide inpatient long-term care, too. The provision would probably have the greatest effect on rural hospitals. First, most rural hospitals are small hospitals, unable to furnish long-term care under current law. Second, because occupancy rates for rural nursing homes are generally very high, it is commonly believed that there is unmet demand for long-term care beds in rural areas.

Estimates of the cost of this provision are necessarily uncertain. It is especially difficult to predict how hospitals will respond to the possibility of providing long-term care services. Experiments conducted by HHS in 61 rural hospitals indicate that the responsiveness of individual hospitals varies widely. On the basis of these experiments, HHS has estimated that a national swing-bed program for rural hospitals only would cost from $6 to $37 million in 1980. The

midpoint of this range (about $22 million) would reflect 925,000 days of hospital long-term care, a roughly 1.5 percent increase in the total number of inpatient days in rural hospitals. Using these figures, and assuming that urban hospitals would be 75 percent less responsive, a swing-bed program for all hospitals would furnish almost 1.7 million days of hospital long-term care at a total cost of $40 million.

The distribution of this total cost among payers is uncertain. Among the experimental hospitals, the payment distribution varied widely, partly because the hospitals provided varying mixes of skilled nursing, intermediate, and personal care. For this estimate, it is assumed that medicare and medicaid each would bear a third of the additional costs, an assumption that is within the range of the experimental data. Full-year federal medicare and medicaid costs in fiscal year 1980 would therefore be $13 million and $7 million, respectively.

Because it is assumed that no swing-bed agreements would become operational until six months after the assumed effective date, costs in fiscal year 1981 are shown for the last quarter only. Costs in the first four quarters are halved because initial agreements are assumed to be made throughout that period. Costs in future years are assumed to rise according to CBO's projected increases in medical care prices.

Under the second part of Section 20, for a particular hospital, the special reimbursement rate for hospital long-term care days would be the average medicaid payment for routine services per day of care in skilled nursing facilities in the state in which the hospital is located plus the reasonable cost of ancillary services provided by the hospital. The special rate would apply only when both (1) the hospital's occupancy rate for the preceding year was less than 80 percent and (2) the local Professional Standards Review Organization (PSRO) has determined that the State Health Planning and Development Agency (SHPDA) could grant the hospital a certificate-of-need for provision of long-term care services. Because medicaid payments for inpatient hospital services cannot exceed those that would be made by medicare in the same circumstances, the proposed special rates would effectively limit medicaid reimbursement as well.

Currently, under medicare, inpatient hospital care provided only because necessary long-term care services are unavailable is reimbursed at normal medicare rates for inpatient hospital services. Consequently, the provision would reduce medicare payments for such care. Under medicaid, most states follow current medicare practices regarding such care, but some already limit reimbursement to skilled nursing or intermediate care facility rates, and still others do not pay for such care at all. Thus, for medicaid, the effect of the provision would be reduced somewhat.

One study of medicare and medicaid hospital patients indicates that approximately 3 percent of medicare and medicaid hospital days (about four million days) are provided only because required long-term care services are unavailable. Based on the results of the study, CBO estimates that 20 percent of these medically unnecessary hospital days would escape PSRO review altogether (because of the periodic nature of that review). CBO assumes that 90 percent of reviewed days would be reimbursed at the special rate. On the basis of current payment data, fiscal year 1980 savings of $80 are estimated for each

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day reimbursed at the lower rate. Thus, gross first-year savings (federal and state) would be about $230 million. The proposed exemptions would sharply reduce potential savings, however. Using the 1978 American Hospital Association (AHA) Survey, CBO estimates that hospitals accounting for 45 percent of all patient days would be exempted because their occupancy rates would exceed 80 percent. In addition, CBO assumes that PSRO determinations regarding certificate-of-need decisions by SHPDAs would reduce savings by one-third. Net first-year federal and state savings would, therefore, be $84 million.

The impact of the occupancy exemption would vary substantially according to hospital size and location. Because occupancy rates rise as hospital size increases, proportionately more large hospitals than small ones would be exempted under the provision. Moreover, since large hospitals typically are located in urban areas, proportionately more urban hospitals would be exempted than rural ones. Thus, for example, according to the 1978 AHA Survey, only about 10 percent of hospitals, accounting for roughly 20 percent of hospital beds, would be exempted in states west of the Mississippi. In the Middle Atlantic states, however, almost 60 percent of hospitals, and nearly 70 percent of hospital beds, would be exempted.

The assumed six-month delay in implementation would cut estimated net savings in fiscal year 1981 to $72 million. Two-thirds of this amount ($48 million) is estimated to accrue to medicare. Of the medicaid portion, about $13 million would be federal savings. Savings in subsequent years grow according to CBO's projections of increases in total annual hospital days and in savings per day.

Section 21—Coordinated audits under the Social Security Act

This section would require that audits of providers performed for the purposes of medicaid or of Title V programs be coordinated with medicare audits whenever a provider participates in medicare and in one or both of the other programs. Federal reimbursements for state expenditures for medicaid or for maternal and child health programs would be reduced for any state not conducting common audits. The amount paid to the state would be reduced to the amount that would have been paid for auditing expenses had the state conducted common audits.

Eliminating duplicative audits should reduce administrative costs for providers, states, and the federal government. A rough estimate of potential federal savings is derived in the following manner.

HCFA estimates that medicare audits will cost about $63 million in fiscal year 1980. This figure includes the costs of coordinated medicaid audits in the more than 30 states that already perform such audits. A comparable HCFA estimate of the costs of medicaid audits is unavailable because states do not routinely report such costs. Assuming that audit costs per participating provider are identical for medicare and medicaid, however, CBO estimates that, in the absence of any coordinated audits, medicaid audits would cost about $47 million in fiscal year 1980. The 16 states and territories that were not performing common audits on June 30, 1977 accounted for about 25 percent of total medicaid administrative expenditures that year. Thus, medicaid audit costs for those states that would be affected by Section 21 are estimated to be about $12 million in fiscal year 1980 and $13 million in fiscal year

1981. The federal share of these expenditures is $7 million. Assuming arbitrarily that 80 percent of this amount would be saved through coordinated audits, over $5 million would be saved by the federal government during fiscal year 1981. Because the provision is assumed to be effective for just three-quarters of the year, however, the estimated savings shown have been reduced to $4 million. Savings in future years are assumed to increase according to CBO's projections of the Consumer Price Index.

Section 23—Demonstration projects relating to the training of AFDC recipients as home health aides

This provision would allow up to twelve States to have demonstration programs for training AFDC recipients to provide supportive services to people who might be expected to require institutional care in the absence of such services. The individuals to whom the services would be available include aged, disabled, and mentally retarded persons whose income does not exceed 200 percent of their State's standard of need. The provision would have both costs and savings. Costs would be incurred for the training of these AFDC recipients and later for Federal payments to cover the wages and expenses of both the AFDC recipients and others employed in providing supportive services. Savings would result from not institutionalizing the individuals receiving the supportive services and from reduced benefit payments to those AFDC recipients employed in providing such services. Savings would occur in the food stamps and medicaid programs as well as in the AFDC program. CBO's estimates of the costs of these demonstration projects should be regarded as illustrative only. Costs would vary substantially depending on the number of such projects funded and on the number of persons participating.

Section 24—Reimbursement for health maintenance organizations

This section would revise a medicare reimbursement option currently available to health maintenance organizations (HMO) in order to make the option more attractive to them. Under present law HMOs may choose to be paid on the basis of either incurred costs or a risk reimbursement formula. Almost all HMOs have chosen the latter option because the current risk formula involves a number of retrospective adjustments that HMOs find undesirable. The current formula would be replaced by a prospective formula that would reimburse an HMO at 95 percent of the average medicare cost per capita for medicare beneficiaries in the HMO's geographic area. If the actual amount of reimbursement exceeds what the HMO would have been reimbursed under a community-rating system, the HMO would be required to provide its medicare enrollees additional benefits that are actuarially equal to the excess. HMOs that are being reimbursed under the current risk formula could continue to be reimbursed under that formula. Medicare beneficiaries enrolled in HMOs choosing the new risk formula could decide whether or not they wanted their benefits to be financed on this basis.

CBO's estimates were derived by adjusting estimates made by OFAA to reflect an assumed effective date of July 1, 1981. The OFAA estimates assume that the average per capita cost for a medicare beneficiary who is an HMO enrollee is 80 percent of the cost for non-

enrollees. This is based on several studies of the difference in medical care costs between HMO and non-HMO populations. The cost of the provision would be generated by the difference between the proposed 95 percent reimbursement rate and the current 80 percent rate for each affected enrollee. Part of these additional costs is assumed to be offset by an increased number of medicare enrollees who would enroll in HMO plans because of the benefits that would be provided in addition to the basic medicare benefits. The per capita cost for these individuals is assumed to fall from 100 percent to 95 percent of the average per capita cost for nonenrollees. Costs in fiscal years 1981 and 1982 would be small because the new risk formula would take effect at the start of new accounting years and because medicare beneficiaries are assumed to shift gradually to the new reimbursement method.

The definition of HMO incorporated in this version of this provision is broader than that in the version contained in H.R. 4000 as reported by the House Ways and Means Committee on November 5, 1979. Because of the substantial uncertainty among experts regarding the impact of this change, CBO's estimates do not reflect any impact from it. It is possible, however, that costs would be considerably greater than estimated.

Section 26—Reimbursement of clinical laboratories under medicare and medicaid

Section 26, which would reduce medicare and medicaid payments for clinical laboratory services, has two parts. One would limit medicare and medicaid reimbursements for laboratory services billed by physicians. The other would allow state medicaid programs to purchase laboratory services through competitive bidding or other similar arrangments for a three-year trial period.

The first part of this section principally would affect laboratory services billed by physicians but not performed by them. In such instances, much of the physician's markup of the laboratory's actual charge would be eliminated. Both the amount of the typical markup and the potential reduction under this provision are uncertain, but 10 percent savings are assumed to be achieved for this estimate. By projecting program data, CBO estimates that medicare payments for the affected laboratory services will be about $190 million in fiscal year 1981. Comparable federal medicaid payments are estimated to be about $60 million in the same year. Savings for three quarters of 1981 thus would be $14 million in medicare and $5 million in medicaid. Savings are assumed to grow 10 percent each year.

On the basis of several studies, CBO assumes that competitive bidding arrangements would reduce medicaid expenditures for laboratory services by 20 percent. CBO estimates that federal medicaid payments for laboratory services billed by laboratories will be roughly $110 million in fiscal year 1981. If all states were assumed to purchase all directly billed laboratory services through competitive bidding, full first-year savings could be as much as $22 million. Under more reasonable assumptions, however, savings would be considerably lower. Assuming that the twenty largest state medicaid programs adopt competitive bidding procedures for the most common tests directly pur-

chased, savings would be about $10 million. Savings shown for fiscal year 1981 are for three quarters only because of assumed lead-time required for implementation. Because this part of Section 26 would expire June 30, 1983, savings in fiscal year 1983 are also for three quarters only.

Section 29—Extended medicaid coverage for the severely medically impaired

The substantial gainful activity (SGA) limit under current law is $280 a month in gross earnings. Any disabled SSI recipient with earnings above this level, after a trial work period, loses his disability status, his SSI eligibility, and his automatic medicaid eligibility (in states in which SSI recipients are automatically eligible for medicaid). H.R. 3464, the Supplemental Security Income Disability Amendments of 1979, as passed by the House on June 6, 1979, contains provisions which would effectively raise the SGA to $444 per month for disabled persons without impairment-related work expenses. For those with such expenses, the SGA would be even higher. Section 29 of H.R. 4000 would essentially eliminate the SGA entirely for the purpose of determining the continued medicaid eligibility of severely disabled persons. The provision would require continuation of medicaid eligibility for severely disabled SSI recipients who lose their SSI payment because of excessive earnings, provided that their earnings are deemed insufficient to allow them to pay for their medical care themselves.

Section 29 has been drafted as if H.R. 3464 already had been enacted in the form in which it passed the House. In fact, that bill has not yet become law in any form. CBO's estimates do not assume enactment of H.R. 3464. Were H.R. 3464 enacted before H.R. 4000, however, the costs of Section 29 would drop considerably. Because of overlaps in the provisions of the two bills, some of the costs shown here would be borne instead by H.R. 3464.

CBO's estimates assume that elimination of the SGA would permit 1,000 severely disabled medicaid recipients to remain eligible for medicaid in fiscal year 1981 who would otherwise have lost their eligibility. In later fiscal years, an additional 4,000 recipients per year are assumed to maintain their eligibility. Each recipient is assumed to receive medicaid benefits equal to the average medicaid benefit for a non-institutionalized disabled public assistance recipient. The federal share of this medicaid cost in fiscal year 1981 is estimated to be about $850 per recipient.

Section 30—Continuing medicaid eligibility for certain individuals by disregarding certain involuntary increases in income

This provision would require that cost-of-living increases in social security benefits, railroad retirement benefits, civil service pensions, veterans compensation, and veterans pensions all be subtracted from income when determining continuing eligibility for medicaid benefits after May 1980.

Estimates shown for fiscal years 1981 through 1985 were provided by OFAA. Those estimates assume that each year 30,000 medicaid eligibles would not lose their eligibility because of this provision. CBO estimates that costs during fiscal year 1980 would be small.

Because the effective date is late in the fiscal year, fewer individuals would be affected by cost-of-living increases, and those affected would be eligible for at most three months of additional medicaid benefits.

Section 31—Limitation on medicaid eligibility for individuals who dispose of assets

Section 31 would allow states to deny medicaid eligibility for as long as two years to persons selling their assets for less than market value in order to acquire medicaid eligibility. The provision would not apply to SSI recipients, except in the 15 states in which SSI recipients are not automatically eligible for medicaid. Because, under current law, states may deny AFDC eligibility—and thus medicaid eligibility—in such circumstances, the provision would apply principally to persons not receiving cash assistance. In particular, it would affect those entering long-term care facilities and dumping assets in order to qualify for medicaid.

Estimated savings are based on CBO estimates for a similar provision in H.R. 934, the Medicare-Medicaid Administrative and Reimbursement Reform Act of 1979, as ordered reported by the Senate Finance Committee on June 28, 1979. That provision would have applied to SSI recipients as well, but would have limited denial of eligibility to one year only.

Section 32—Adjustment of dollar limitation and elimination of special limitation on medicaid payments to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, American Samoa, and the Trust Territory of the Pacific Islands

Section 32 would double the ceilings on federal funding for medicaid programs in the territories and remove the 50 percent limitation on the federal medical assistance percentage for those programs. After fiscal year 1981, the ceilings would be indexed to the Consumer Price Index.

This provision is assumed to affect federal spending in fiscal year 1980. Projections of medicaid expenditures in Guam, Puerto Rico, and the Virgin Islands indicate that the proposed ceilings on federal medicaid spending in these jurisdictions would be binding (that is, annual federal medicaid expenditures would equal the proposed ceilings). Because the current ceilings are binding today, the estimated costs are the sums of the differences between the current and proposed ceilings. No costs are shown for territories that do not have medicaid programs today.

Section 33—Extension of increased funding for skilled nursing facility inspectors under medicaid

This provision would continue for three years 100 percent federal funding of training and salaries for inspectors of long-term care facilities. In the absence of this provision, federal funding would revert to 75 percent of such costs after fiscal year 1980. The provision is assumed to take effect October 1, 1980. Estimates provided by HCFA have been rounded by CBO.

Section 34—Extension of increased funding for State medicaid fraud control units

Under current law, the federal share of costs for development and operation of state medicaid fraud control units would drop from 90

percent to 50 percent on October 1, 1980. Section 34 would instead maintain 90 percent federal funding for the first three years for each unit and provide 75 percent federal funding thereafter.

The costs of this provision are sensitive to assumptions about state responses to the level of the federal subsidy for the anti-fraud program. At one extreme, it is possible that no state would run a fraud control unit at just 50 percent federal support; at the other, in response to 90 percent federal funding, all states eventually might develop and operate such units. Under these assumptions, and disregarding any savings, the cost of this section in fiscal year 1981 could be almost $55 million.

The Administration's budget assumptions underlie CBO's estimates. At the beginning of fiscal year 1980, 25 states were operating medicaid fraud control units. The Administration assumes that another 16 states will develop such units before the end of the fiscal year, leaving just 9 states without them. In fiscal year 1981, however, when federal funding reverts to 50 percent, the Administration assumes that 12 of these new programs will terminate. Under this provision, for fiscal year 1981, CBO assumes slight expansion of the 25 older programs, very rapid growth in the 16 programs new in fiscal year 1980, and development of no additional programs. The gross cost of this provision in fiscal year 1981 would be about $26 million with these assumptions. Based on recent program experience, federal savings as the result of restitutions and fines are estimated to be about 45 percent of federal costs. Subtracting these savings yields net costs of $15 million in fiscal year 1981. Estimates may understate savings and overstate costs insofar as they do not assume any deterrent effect from the fraud control activities.

In fiscal year 1982, in spite of inflation, costs should stabilize as federal funding for the older units falls to 75 percent. By the end of fiscal year 1983, all units will be subsidized at 75 precent, so that costs will begin to rise again with inflation in fiscal years 1984 and 1985. CBO's estimates assume constant federal spending at fiscal year 1981 levels under current law.

Section 35—Medicaid payments to States (*Fund drawdown*)

Section 35 would require that medicaid payments to the states not be made before actual presentation of state medicaid checks for payment. The provision would also allow substitution of an estimating procedure for a check-by-check payment system. The section would speed up implementation of a cash management change first proposed in the Administration's 1980 budget and again in revised form in the 1981 budget. This provision would require full implementation of the change by December 31, 1980 instead of by the end of fiscal year 1981, as planned by the Administration.

Under current policy, savings of $182 million and $117 million are assumed to be achieved in fiscal years 1980 and 1981 respectively. This provision would shift some of these savings from fiscal year 1981 into fiscal year 1980. CBO assumes that one-third of the fiscal year 1981 savings are shifted into fiscal year 1980. The provision therefore would save $39 million in fiscal year 1980 and cost $39 million in fiscal year 1981. In addition to its impact on medicaid outlays, however, the

provision would generate about $5 million in earned interest in fiscal year 1981.

Section 36—Change in calendar quarter for which satisfactory utilization review must be shown to receive waiver of medicaid reduction

Section 36 would make technical changes regarding retroactive reductions of federal medicaid payments to states because of failure to meet certain utilization review requirements. The effect of the changes would be to eliminate an $8 million reduction otherwise applicable to payments to be made to the state of Colorado. CBO assumes that the provision would affect fiscal year 1981 outlays only.

Section 37—Demonstration projects for requiring second opinions for certain elective surgical procedures under medicare and medicaid

Section 37 would require that HHS, "to the extent feasible," conduct at least seven demonstration projects for the purpose of evaluating the impact of second medical opinions with respect to specified elective surgical procedures. For participating individuals (those giving informed consent), such opinions would be mandatory as a condition of payment for the specified surgery under medicare and medicaid. Each experiment would run for two years. For administrative expenses, the section would authorize appropriations in fiscal year 1981 of not more than $7 million.

On the basis of information provided by HCFA, CBO assumes that the full amount authorized would be required to support just six demonstrations. The estimates shown assume that the full amount authorized would be appropriated and further assume that most of the funds would be spent starting up the projects. In addition to administrative costs, benefit costs for the required second opinions would be incurred. HCFA estimates that these costs would amount to about $2 million over the life of the demonstrations. Because the results of the demonstrations are uncertain by nature. CBO assumes neither costs nor savings as a consequence of the second opinions.

7. Estimate comparison: Estimates of the costs of some sections of this bill have been provided CBO by several different offices within HHS. These are not official HHS estimates, however: official HHS estimates of the costs of the bill are not available at this time. An estimate comparison therefore cannot be made.

8. Previous CBO estimate: On November 20, 1979, CBO prepared estimates of the costs of H.R. 4000 as reported by the Committee on Ways and Means on November 5, 1979. That version of the bill differs in many ways from the one ordered reported by the Commerce Committee, the costs of which are estimated here. The Commerce Committee has added new provisions and modified or deleted others. CBO's estimates of the costs of unaltered provisions differ from CBO's earlier estimates because of later assumed enactment and effective dates. In addition, an error in CBO's earlier estimate of savings from Section 23, regarding demonstration projects for training AFDC recipients as home health aides, has been corrected, reducing estimated savings by $23 million in fiscal year 1985.

9. Estimate prepared by Malcolm Curtis.

10. Estimate approved by:

JAMES L. BLUM,
Assistant Director for Budget Analysis.

B. ESTIMATE OF THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

The following estimates were submitted to the committee by the Health Care Financing Administration's Office of Financial and Actuarial Analysis (Department of Health, Education, and Welfare):

COST ESTIMATES, H.R. 4000

[As approved by House Interstate and Foreign Commerce Committee; in millions]

Section	Fiscal year— 1980	1981	1982	1983	1984
2. Expanded membership Professional Standards Review Organizations	0	0	0	0	0
3. Registered nurse and dentist membership on statewide council advisory group	0	0	0	0	0
4. Nonphysician membership on national PSRO Council	0	0	0	0	0
5. Efficiency in delegated review	0	0	0	0	0
6. Required activities of PSRO's	(1)	(1)	(1)	(1)	(1)
7. Response of PSRO's to Freedom of Information Act requests	0	0	0	0	0
8. Consultation by PSRO's with health care practitioners	0	0	0	0	0
9. Review of routine hospital admission, services and preoperative hospital stays by PSRO's	0	0	0	0	0
10. Study of PSRO norms, standards, and criteria	(1)	(1)	(1)	(1)	(1)
11. Nonprofit hospital philanthropy:					
Medicare	0	60.0	70.0	80.0	90.0
Medicaid	0	9.0	11.0	12.0	14.0
12. Repeal of consultative services for SNF's	0	0	0	0	0
13. Study of need for dual participation in SNF's	(1)	(1)	(1)	(1)	(1)
14. Alternative to decertification of SNF's	0	0	0	0	0
15. Life Safety Code requirements	0	0	0	0	0
16. Criminal standards for certain medicare- and medicaid-related crimes	0	0	0	0	0
17. Exclusion of health care professionals convicted of medicare- or medicaid-related crimes	0	0	0	0	0
18. Requirement concerning reporting financial interest	0	0	0	0	0
19. Withholding of Federal share of payments to medicaid providers to recover medicare overpayments	(1)	(1)	(1)	(1)	(1)
20. Hospital providers of long-term care services:					
Swing beds	(1)	(1)	(1)	(1)	(1)
Differential reimbursement	(1)	−20.0	−30.0	−35.0	−40.0
21. Coordinated audits under the Social Security Act:					
Medicare	0	−6.0	−6.0	−6.0	−6.0
Medicaid	0	−26.0	−26.0	−26.0	−26.0
22. Medigap	0	0	0	0	0
23. Demonstration projects relating to the training of AFDC recipients as home health aides	(2)	(2)	(2)	(2)	(2)
24. Reimbursement of HMO's [3]	0	5.0	25.0	35.0	40.0
25. Quality assurance program for clinical laboratories	0	0	0	0	0
26. Reimbursement of clinical laboratories under medicare and medicaid:					
Medicare	(1)	−14.0	−22.0	−26.0	−29.0
Medicaid	(1)	−2.0	−2.0	−3.0	−3.0
27. Reimbursement of physicians' services in teaching hospitals	0	0	0	0	0
28. Reimbursement under medicaid for services furnished by nurse-midwives	(2)	(2)	(2)	(2)	(2)
29 Extended medicaid coverage for the severely medically impaired	(1)	3.0	7.0	11.0	15.0
30. Continuing medicaid eligibility for certain individuals by disregarding certain involuntary increases in income	(1)	11.0	27.0	49.0	75.0
31. Limitation on medicaid eligibility for individuals who dispose of assets	(1)	(1)	(1)	(1)	(1)
32. Adjustment medicaid payments to Puerto Rico, Guam, the Virgin Islands, the Northern Marianas, American Samoa, and the trust territories	32	34.0	34.0	34.0	34.0
33. Extension of increased funding for nursing home inspectors under medicaid	NA	9.1	9.8	10.6	NA
34. Extension of increased funding for State medicaid fraud control units		21.6	23.0	25.6	25.2
35. Medicaid payments to States (fund draw down): [4]					
Outlay deferral	−122	−73.0			
Interest earnings		−20.6			
36. Change in calendar quarter for which satisfactory utilization review must be shown to receive waiver of medicaid reduction	8	NA	NA	NA	NA
37. Demonstration projects for requiring second opinions	NA	5.0	3.1	NA	NA
38. Informed consent for mandatory demonstration projects					
39. Continued use of demonstration reimbursement projects	(2)	(2)	(2)	(2)	(2)
Net total outlays	−114	16.1	153.9	196.2	229.2

[1] Negligible (less than $1,000,000).
[2] Inestimable.
[3] At this time we do not have the data that we need to properly update this estimate. There is a project underway to gather the needed data which may be completed by the end of 1980.
[4] Outlay deferral line reflects President's budget request minus impact of waiver for States with congressional problems.

C. COMMITTEE ESTIMATE

The Committee concurs with the estimates of the Congressional Budget Office except for the estimated cost effect of Section 35, medicaid payments to States. The Committee believes that HEW is in a better position to accurately estimate the cost impact of this section since its cost is measured in relation to the cost of action that HEW would have taken in the absence of legislation. CBO assumes HEW would take action to save the funds on its own, and the only cost impact of the Committee action is to result in those savings occurring in fiscal year 1980. Since CBO had already assumed those savings in their initial estimate of fiscal year 1981 medicaid expenditures, they assume that the fiscal year 1981 impact of the section is a cost, since the savings were achieved in fiscal year 1980 (more rapidly than HEW anticipated). In the Committee's judgment, to assume a cost to legislation designed to assure that fund drawdown is made effective is misleading and incorrect, particularly since HEW has not to date been successful in achieving the savings without a legislative mandate.

IV. Other Matters To Be Discussed Under The House Rules

VOTE OF THE COMMITTEE

The committee reports that the bill, H.R. 4000, as amended, was ordered favorably reported by a voice vote.

OVERSIGHT FINDINGS

The Committee's principal oversight activities with respect to the medicaid and medicare programs have been conducted by the Subcommittee on Health and the Environment in connection with its consideration of various legislative proposals. The findings are included as part of the explanation of the bill.

The Committee notes that additional oversight hearings have been conducted by the Subcommittee on Oversight and Investigations of this Committee and by the Ways and Means Committee.

No oversight findings or recommendations have been submitted to the Committee by the House Committee on Government Operations with respect to the subject matter contained in the bill.

Agency Reports

Agency reports were requested on H.R. 4000 from the Department of Health, Education, and Welfare and from the Office of Management and Budget.

The following report was received:

EXECUTIVE OFFICE OF THE PRESIDENT,
OFFICE OF MANAGEMENT AND BUDGET,
Washington, D.C., July 24, 1979.

Hon. HARLEY O. STAGGERS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This is in response to your request of June 15, 1979 for the views of this Office on H.R. 4000, a bill "To amend the Social Security Act with respect to health programs authorized under it, and for other purposes."

In testimony before your Committee on June 27, 1979, the Administrator, Health Care Financing Administration, Department of Health, Education, and Welfare explained the Administration's position on H.R. 4000. The Administration supports those provisions in H.R. 4000 that are included in the Administration's proposed "Medicare and Medicaid Amendments of 1979," H.R. 4475. The Administration does not favor the enactment of certain other provisions in H.R. 4000 for the reasons stated in the June 27, 1979 testimony.

Accordingly, we recommend enactment of H.R. 4475 in lieu of H.R. 4000. Enactment of H.R. 4475 would be in accord with the program of the President.

Sincerely,

JAMES M. FREY,
Assistant Director for Legislative Reference.

INFLATION IMPACT

The committee concludes that the changes made in existing law by this bill would not have an inflationary impact on prices and costs in the operation of the national economy.

V. SECTION-BY-SECTION ANALYSIS OF BILL

Section 1

The first section contains the short title of the bill, "Medicare and Medicaid Amendments of 1979."

Section 2. Expanded membership of professional standards review organizations

Section 2 of the bill amends section 1152(b)(1)(A) of the Social Security Act to provide for membership in a PSRO, at the option of the PSRO, of health care practitioners (other than doctors of medicine or osteopathy) engaged in the practice of their professions in the organization's area who hold independent hospital admitting privileges however, such practitioners may not make final determinations with respect to the profesisonal conduct or services of doctors of medicine or osteopathy. (Docors of medicine or osteopathy can be PSRO members under present law.)

Section 3. Registered nurse and dentist membership on statewide council advisory group

Section 3 of the bill amends section 1162(a)(1) of the Social Security Act to require the inclusion of at least one registered professional

nurse and at least one doctor of dental surgery or dental medicine in the membership of an advisory group to a statewide Professional Standards Review Council.

Section 4. Nonphysician membership on National Professional Standards Review Council

Section 4(a) of the bill amends section 1163(a)(1) of the Social Security Act to provide that the membership of the National Professional Standards Review Council will include (in addition to its present membership) one doctor of dental surgery or dental medicine, one registered professional nurse, and one other health practitioner other than a doctor of medicine or osteopathy.

Section 4(b) of the bill amends section 1163(a)(2) of the Social Security Act to provide that the terms of no more than five members of the Council shall expire in any year.

Security 4(c) of he bill amends section 1163(a)(3) of the Social Security Act to provide that the Secretary shall periodically designate one of the physician members of the Council to serve as the Council's chairman.

Section 4(d) of the bill amends section 1163(d) of the Social Security Act to provide that physician members of the Council shall consist of physicians of recogniezd standard and distinction in the appraisal of medicine practice.

Section 4(e) of the bill makes a conforming amendment in section 1173 of the Social Security Act.

Section 4(f) provides that the amendments made by section 4 become effective 180 days after enactment of the bill.

Section 5. Efficiency in delegated review

Section 5 amends Section 1155(e) of the Social Security Act to provide that review may be delegated to a hospital by the PSRO if the hospital can demonstrate its capacity to review efficiently, as well as effectively and in timely fashion (as under current law).

Section 6. Required activities of professional standards review organizations

Section 6(a)(1) amends section 1154(b) of the Social Security Act to limit conditional PSRO required review responsibilities to hospital services (other than ancillary, ambulatory care, and long-term care services) and other duties and functions as the Secretary may require (pursuant to new Section 1154(f)(2) and (f)(4) as added by Section 6(a)(3) and which the organization is capable of performing. Section 6(a)(1) further provides that in order to be a qualified fully designated PSRO the Secretary must find that the organization is substantially carrying out these activities and functions in a satisfactory manner.

Section 6(a)(2) amends section 1154(c) of the Social Security Act to make a conforming change.

Section 6(a)(3) adds a new Section 1154(f) to the Social Security Act.

New Section 1154(f)(1) requires the Secretary to establish a program for the evaluation of the cost-effectiveness of review of particular health care services by PSRO's.

New Section 1154(f)(2) requires the program to be designed in a manner so that the Secretary will require particular PSRO's, chosen by a statistically valid method that will permit a valid evaluation of the cost-effectiveness of such review, to review particular health care services. This is in order to demonstrate the cost-effectiveness of requiring review of such services before such review is generally required.

New Section 1154(f)(3) requires the program to provide for the evaluation of cost-effectiveness of this review, particularly in comparison with areas in which such review was not required or performed.

New Section 1154(f)(4) provides that based upon such evaluation (or upon an evaluation of comparable statistical validity) and a finding that such review is cost-effective or yields other significant benefits, the Secretary shall specify those health care services which PSRO's (either generally or under such conditions and circumstances as the Secretary may specify) have the duty and the function of reviewing.

New Section 1154(f)(5) specifies that the program does not apply to health care services (other than ancillary, ambulatory care, and long-term care services) provided by or in hospitals.

Section 6(b) amends Section 1154(a) of the Social Security Act to provide that PSRO's are required to assume additional review responsibilities only to the extent and at the time specified by the Secretary under new Section 1154(f).

Section 6(c) strikes Section 1155(g) of the Social Security Act pertaining to review in shared health facilities and ambulatory care review.

Section 6(d) amends Section 1155 of the Social Security Act by adding a new subsection (h), which permits the Secretary to designate another qualified PSRO to conduct reviews of services for which a designated PSRO has not assumed review responsibilities.

Section 7. Response of professional standards review organizations to Freedom of Information Act requests

Section 7 provides that no PSRO designated (conditionally or otherwise) shall be required to make available any records pursuant to a request under the Freedom of Information Act until after the end of the 180 day period beginning on the date of entry of a final court order requiring such release.

Section 8. Consultation by professional standards review organizations with health care practitioners

Section 8(a) amends section 1155(a) of the Social Security Act by adding a new paragraph (8), which requires each Professional Standards Review Organization to consult (in a manner prescribed by the Secretary) with representatives of health care practitioners (other than physicians) and of institutional and noninstitutional providers of health care services, in relation to the Professional Standards Review Organization's responsibility for the review of the professional activities of such practitioners and providers.

Section 8(b) amends section 1162(e) of the Social Security Act to delete the requirement that the Professional Standards Review Or-

ganizations in a State which does not have a Statewide Professional Standard Review Council must be advised or assisted by an advisory group of not less than 7 nor more than 11 members who are representatives of health care practitioners, other than physicians.

Section 8(c) provides that the amendments made by section 8 become effective 180 days after the date of enactment.

Section 9. Review of routine hospital admission services and preoperative hospital stays by professional standards review organizations

Section 9 amends section 1155(a)(2) of the Social Security Act to authorize each Professional Standards Review Organization to determine, in advance, the medical necessity and appropriateness of any elective admission to a hospital or other health care facility (including admissions occurring on weekends) and any routine diagnostic services furnished in connection with such an admission.

Section 10. Study of PSRO norms, standards, and criteria

Section 10 requires the Secretary to conduct, in consultation with the National Professional Standards Review Council, a nationwide study of the differences in medical criteria and length-of-stay norms utilized by Professional Standards Review Organizations in the various regions of the country and to report the findings and conclusions made with respect to the study to the Congress within one year of the date of enactment.

Section 11. Nonprofit hospital philanthropy

Section 11(a) adds a new section 1132, entitled "Encouragement of Nonprofit Hospital Philanthropy" to the Social Security Act.

New section 1132(a) states that it is the policy of the United States that philanthropic support for health care be encouraged and expanded, especially in support of experimental and innovative efforts to improve the health care delivery system.

New section 1132(b) states that for purposes of determining reasonable costs of services furnished by nonprofit hospitals under titles V, XVIII and XIX, unrestricted grants, gifts, and income from endowments shall not be deducted from any operating costs of such hospitals. In addition, the section provides that the following items shall not be deducted from any operating costs of such hospitals:

(1) A donor designated or restricted grant, gift, or income from an endowment, as these terms are defined for provider reimbursement under Medicare in 42 C.F.R. 405.423(b)(2);

(2) An unrestricted grant or gift, or income from such a grant or gift, which is not available for use as operating funds because of its designation by the hospital's governing board;

(3) A grant or similar payment which is made by a governmental entity and which is not available, under the terms of the grant or payment, for use as operating funds;

(4) The sale or mortgage of any real estate or other capital assets of the hospital which the hospital acquired through a gift or grant and which is not available for use as operating funds under the terms of the gift or grant or because of its designation by the hospital's governing board, except for recovery of the appropriate share of gains and losses realized from the disposal of depreciable assets; and

(5) A sinking fund which is (A) created by the hospital in order to meet a condition imposed by a third party for the third party's financing of a capital improvement of the hospital, and which fund is used exclusively to make payments to such third party for the financing of the capital improvement.

Section 6(b) provides that the new section 1132 of the Social Security Act shall apply to grants, gifts, and endowments made or established on or after the date of enactment of the bill.

Section 12. Consultative services for skilled nursing facilities

Section 12 amends section 1864(a) of the Social Security Act to repeal the provisions authorizing Medicare reimbursement for consultative services furnished by State agencies to skilled nursing facilities.

Section 13. Study of need for dual participation of skilled nursing facilities

Section 13(a) requires the Secretary to conduct, after appropriate consultation, a study of the availability and need for skilled nursing facility services covered under Part A of title XVIII of the Social Security Act and under State plans approved under title XIX of such Act.

Section 13(b) requires the Secretary to complete this study and submit a report (including any recommendations for administrative or legislative changes), to the Committee on Finance of the Senate and to the Committee on Ways and Means and the Committee on Interstate and Foreign Commerce of the House of Representatives within one year after enactment.

Section 14. Alternative to decertification of long-term-care facilities out of compliance with conditions of participation; look-behind authority

Section 14(a) amends section 1866 of the Social Security Act by adding a new subsection (f), which permits the Secretary to deny payment for services furnished to Medicare and Medicaid beneficiaries after a specified date by a skilled nursing facility out of compliance with the provider conditions of participation if the deficiencies do not immediately jeopardize the health and safety of patients. The section provides for similar action while decertification is underway if life and safety are immediately endangered. Subsection (f) further requires the Secretary to provide the facility the opportunity to correct its deficiencies, to provide a hearing for the facility before such denial of payment, and to provide notification to the facility and the public concerning such action.

Section 14(b)(1)(A) adds a new Section 1902(h) to the Social Security Act which authorizes similar State actions with respect to skilled nursing facilities and intermediate care facilities determined out of compliance under Medicaid.

Section 14(b)(1)(B) amends Section 1902(a)(33)(B) to authorize the Secretary to validate State determinations, and on that basis make independent and binding determinations, concerning the extent to which individual institutions and agencies meet the requirements for participation.

Section 14(b)(2) amends Section 1910 by adding a new subsection (c). New Section 1910(c)(1) provides that the Secretary may cancel approval of any skilled nursing or intermediate care facility under Medicaid at any time if he finds on the basis of a determination made by him that a facility fails to meet the appropriate requirements for participation under Medicaid, or if he finds grounds for termination of the provider agreement under Medicare. In that event the Secretary shall notify the State agency and the skilled nursing facility or intermediate care facility that approval of eligibility of the facility to participate in the programs established by Medicare and Medicaid shall be terminated at a time specified by the Secretary. The approval of eligibility of any such facility to participate in such programs may not be reinstated unless the Secretary finds that the reason for termination has been removed and there is reasonable assurance that it will not recur. The new Section 1910(c)(2) provides that any skilled nursing facility or intermediate care facility which is dissatisfied with a determination by the Secretary that it no longer qualifies as such a facility for Medicaid, shall be entitled to a hearing by the Secretary and to judicial review.

Section 1910(c)(2) further provides that any agreement between such facility and the State agency shall remain in effect until the period for filing a request for a hearing has expired or, if a request has been filed, until a decision has been made by the Secretary. The agreement shall not be extended if the Secretary make a written determination (specifying the reasons) that the continuation of provider status constitutes an immediate and serious threat to the health and safety of patients, and the Secretary certifies that the facility has been notified of its deficiencies and has failed to correct them.

Section 15. Life Safety Code requirements

Section 15 amends section 1861(j)(13) of the Social Security Act to delete the requirement that a skilled nursing facility must meet the 1973 edition of the Life Safety Code of the National Fire Protection Association, and to provide that such facility must meet applicable provisions of such edition of the Code as is specified in regulations.

Section 16. Criminal standards for certain medicare and medicaid-related crimes

Section 16 amends Sections 1877(b) and 1909(b) of the Social Security Act to clarify the provisions of current law that establish criminal penalties for solicitation or receipt of kickbacks, bribes, rebates or other remuneration in exchange for medicare and medicaid business. Section 16 specifies that such conduct does not constitute a felony unless it is knowing and willful.

Section 17. Exclusion of health care professionals convicted of medicare or medicaid-related crimes

Section 17(a) amends title XI of the Social Security Act by adding a new section 1127.

Subsection (a) of new section 1127 requires the Secretary to bar from participation in the programs established by titles XVIII and XIX of the Social Security Act any physician or other individual who has been convicted of a criminal offense related to either program.

Subsection (b) of new section 1127 specifies the manner in which the Secretary's determination under section 1127 will become effective.

Subsection (c) of new section 1127 specifies the right of any person adversely affected by a determination of the Secretary under section 1127(a) to a hearing on the record and to judicial review of the determination.

Section 17(b) amends section 1862(e) of the Social Security Act to prohibit payment under title XVIII to physicians or other individuals barred, under section 1127, from participation in the program.

Section 17(c) amends section 1902(a)(39) of the Social Security Act to prohibit payment under title XIX to physicians or other individuals barred under section 1127 from participation in the program.

Section 17(d) makes a conforming amendment to section 1902 of the Social Security Act by repealing subsection (g).

Section 18. Requirements concerning reporting of financial interest

Section 18(a) amends section 1124(a)(3)(A)(ii) of the Social Security Act to provide that a disclosing entity is required to report only those individual interests in mortgages or other obligations equal to at least $25,000 or 5 percent of the entity's total assets.

Section 18(b) amends section 1902(a)(35) to require the State plan under title XIX to provide that any entity receiving payments under such plan complies with the disclosure of ownership and related information requirements of section 1124.

Section 19. Withholding of Federal share of payments to medicaid providers to recover medicare overpayments

Section 19(a) amends the provisions of section 1902(a)(13) of the Social Security Act relating to State plan requirements for payment for inpatient hospital, skilled nursing facility, and intermediate care facility services to prohibit such payment where the State agency is subject to an order under new section 1913, added by subsection (d) of section 19 of the bill.

Sections 19(b) and 19(c) make technical conforming amendments to section 1903, relating to payment to States.

Section 19(d) amends title XIX of the Social Security Act by adding a new section 1913, which permits the Secretary to withhold the Federal share of Medicaid payments to an institution (or person) that participates or has participated in (or has accepted assignment under) Medicare and from which the Secretary has been unable to recover (or determine the amount of) Medicare overpayments. New section 1913 further requires the Secretary to provide notice to the State agency and the provider of such action, and directs him to promulgate regulations to implement this section.

Section 20. Hospital providers of long-term-care services ("swing-beds")

Section 20(a)(1) amends title XVIII of the Social Security Act by adding a new section 1882 entitled "Hospital Providers of Extended Care Services."

New section 1882(a)(1) provides that any hospital (other than a hospital which has in effect a waiver of the 24-hour nursing service requirement imposed by section 1861(a)(5) of the Social Security

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Act) which has filed an agreement under section 1866 of the Social Security Act (relating to the charges a hospital may make for the medicare deductibles and coinsurance) may (subject to subsection (b) of this new section), enter into an agreement with the Secretary under which its inpatient facilities may be used to furnish services of the type which, if furnished by a skilled nursing facility, would constitute post-hospital extended care services.

New section 1882(a)2) (A) and (B) provides that, notwithstanding any other provision of title XVIII of the Social Security Act, payment for services furnished under an agreement entered into under this new section shall be based on the reasonable cost of routine services (as determined under clause (ii) of paragraph (B)) and the reasonable cost of ancillary services (as determined under clause (iii) of paragraph (B)). Clause (ii) of paragraph (B) provides that the reasonable cost of routine services furnished during any calendar year is equal to the product of the number of patient days during the year for which the services were furnished and the average reasonable cost per patient day (such average being the average rate per patient day paid for routine services during the previous calendar year under title XIX of the Social Security Act to skilled nursing facilities located in the State in which the hospital is located and which have agreements under sec. 1902(a)(28) of the Social Security Act). Clause (iii) of paragraph (B) provides that the reasonable cost of ancillary services shall be determined in the same manner as for inpatient hospital services.

New section 1882(b) provides that the Secretary may not enter into an agreement under this section unless the hospital has been granted a certificate of need for the provision of long-term care services from the State health planning and development agency (designated under sec. 1521 of the Public Health Service Act).

New section 1882(c) provides that an agreement with a hospital under this section shall, except as otherwise provided by the Secretary in regulations, be subject to termination on the same conditions and impose the same duties, responsibilities, conditions, and limitations as agreements entered into under section 1866 of the Social Security Act. A hospital whose agreement under this section has been terminated is not eligible to enter a new agreement under this section for at least 2 years from the termination date.

New section 1882(d) provides that payment may be made to a hospital under an agreement entered into under this section for extended care services only if payment would have been made for such services if they had been furnished by a skilled nursing facility; and individuals on whose behalf such payments are made shall be deemed, for purposes of title XVIII of the Social Security Act, to have received post-hospital extended care services.

New section 1882(c) provides that during the period a hospital has in effect an agreement under this section, the total reimbursement received for routine services from all classes of long-term care patients shall be subtracted from the hospital's total routine costs before calculations are made to determine medicare's reimbursement for routine hospital services.

New section 1882(f) requires a hospital which enters into an agreement with the Secretary under section 1883 to meet those conditions

applicable to skilled nursing facilities relating to discharge planning and the social services function (and staffing requirements to satisfy it) which are promulgated by the Secretary under section 1861(j)(15). Services furnished by such a hospital, which would otherwise constitute post-hospital extended care services if furnished by a skilled nursing facility, are subject to the same requirements applicable to such services when furnished by a skilled nursing facility except for those requirements the Secretary determines are inappropriate.

New section 1882(g) requires the Secretary to prescribe an alternative method for determining the reasonable cost of post-hospital extended care services furnished in a distinct part of a hospital certified as a skilled nursing facility under section 1861(j) that is the same "swing-bed" method provided in new section 1882.

Section 20(a)(2) amends section 1861(v)(1) by adding a new subparagraph (G), relating to in patient services that would otherwise constitute post-hospital extended care services if furnished by a skilled nursing facility.

New subparagraph (G) requires payment for such services to be computed as provided in new section 1882(a), if the following conditions are met: (1) such services are furnished on the basis of a determination by a Professional Standards Review Organization (or other authorized review organization) that post-hospital extended care services are medically necessary and such services are not otherwise available; (2) such hospital has had, during the immediately preceding calendar year, an average daily occupancy rate of less than 80 percent; and (3) such hospital could be granted a certificate of need for the provision of long-term services from the designated State health planning and developing agency for the State in which the hospital is located. New subparagraph (G) further provides that where such payment is made, the individual who is furnished such services will be deemed, for purposes of title XVIII, to have received post-hospital extended care services. In addition, the Secretary is required to submit to the Congress, within 3 years after the date of enactment, a report evaluating the program established by the amendment made by section 20(a)(1) of the bill.

Section 20(b) of the bill amends title XIX of the Social Security Act by adding a new section 1914, entitled "Hospital Providers of Skilled Nursing and Intermediate Care Services." New section 1914 conforms medicaid reimbursement for skilled nursing facility services and intermediate care facility services furnished by a hospital (including a long-term care provided in a distinct part of the hospital) with an agreement under new section 1882 to the "swing-bed" payment provisions of that section.

Section 20(c) provides that the amendments made by section 20 become effective on the date on which final implementing regulations are first issued; and provides further that those regulations must be issued not later than the first day of the sixth calendar month following the month in which the bill is enacted.

Section 21. Coordinated audits under the Social Security Act

Section 21(a) of the bill amends title XI of the Social Security Act by adding at the end thereof a new section 1128 entitled "Coordi-

nated Audits." The new section 1128(a) provides that if any entity furnished services that are reimbursable on a cost-related basis under titles V or XIX, as well as under title XVIII of the Social Security Act, the Secretary shall require, as a condition of payment to any State under titles V or XIX with respect to administrative costs incurred in the performance of audits of that entity, that these audits be coordinated with audits performed for purposes of title XVIII of such act. The Secretary shall specify the method for apportioning the cost of coordinated audits among the programs established under these titles. Where a State has declined to participate in a common audit with respect to titles V or XIX, the Secretary shall reduce the payments otherwise due the State under such titles by an amount he estimates exceeds the amount that would have been apportioned to the State (for the expenses of the State incurred in the common audit) if it had participated in the common audit.

New Section 1128(b)(1) requires the Secretary to conduct one or more demonstration projects to test the feasibility of a single coordinated appeal process to resolve disputes arising from coordinated audits. New Section 1128(b)(2) provides that the Secretary may waive such requirements of titles V, XVIII and XIX as would prevent carrying out the project, require duplicative activity or otherwise create unnecessary burdens. New section 1128(b)(3) requires the Secretary to report to Congress no later than April 1, 1982 on the projects including reaction of entities involved, estimates of savings, and legislative recommendations deemed appropriate.

New Section 1128(b)(4) requires the Secretary to review the feasibility of establishing a single coordinated process for the collection of overpayments established by a coordinated audit and to report his findings and recommendations to the Congress by April 1, 1981.

Section 21(b)(1) of the bill amends Section 1902(a) of the Social Security Act by adding a new paragraph (41) which makes conforming amendments in title XIX of the Social Security Act with respect to the performance of common audits of entities also providing services under XVIII of the Social Security Act and the apportionment of the cost for the performance of such common audits.

Section 21(b)(2) of the bill provides that the new paragraph (41) shall apply to medical assistance provided under a State plan approved under title XIX of the Social Security Act, on or after the first day of the first calendar quarter beginning more than 30 days after the date of enactment of the bill except where State legislation is required. In this case the State is given until the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of the bill.

Section 21(c)(1) of the bill amends Section 505(a) of the Social Security Act by adding a new paragraph (15) which makes conforming amendments in title V of the Social Security Act with respect to the performance of common audits of entities also providing services under title XVIII of such act and the apportionment of the cost for the performance of such common audits.

Section 21(c)(2) of the bill provides that the new paragraph (15) shall apply to services provided, under a State plan approved under title V of the Social Security Act, on or after the first day of the first

calendar quarter beginning more than 30 days after the date of enactment of the bill.

Section 21(d) of the bill requires the Secretary to report to the Congress, no later than July 1, 1980, on the actions he has taken to: (1) coordinate the conduct of institutional audits and inspections required under the programs funded under titles V, XVIII, or XIX of the Social Security Act; and (2) coordinate such audits and inspections with those conducted by other cost payers. The Secretary is to include in this report such legislative recommendations as he deems appropriate to assure maximum feasible coordination of such institutional audits and inspections.

Section 22. Voluntary certification of medicare supplemental health insurance policies

Section 22(a)(1) amends Title XVIII of the Social Security Act by adding a new Section 1882 entitled "Voluntary Certification of Medicare Supplemental Health Insurance Policies".

New Section 1882(a) requires the Secretary to establish a procedure whereby medicare supplemental policies may be certified by him as meeting minimum standards set forth in new Section 1882(c). The procedure must provide an opportunity for any insurer to submit any such policy, and such additional data as the Secretary finds necessary, to him for his examination and certification as meeting the minimum standards. The section provides that the certification shall remain in effect, if the insurer both files a statement with the Secretary no later than December 31 of each year stating that the policy continues to meet the minimum standards and submits such additional data as the Secretary finds necessary to independently verify the accuracy of such notarized statement. Where the Secretary determines such a policy meets (or continues to meet) the required standards, he shall authorize the insurer to have printed on such policy an emblem (designed under his authority) indicating that a policy has received the Secretary's certification. The section further requires the Secretary to provide each State insurance commissioner with a list of all certified policies.

New Section 1882(b) provides that any medicare supplemental policy (including any mail order policy) issued in any State which has established under State law a regulatory program requiring compliance with minimum standards with respect to such policies equal to or more stringent than the minimum standards under the new certification procedure shall be deemed (for so long as the Secretary finds such State program continues to require compliance with such standards) to meet the Federal minimum standards.

New Section 1882(c) prohibits the Secretary from certifying any medicare supplemental policy for any period, nor continuing a certification for any period, unless he finds that for such period the policy meets the following conditions:

(1) The policy must meet standards set forth by the Secretary with respect to adequacy of coverage (either in a single policy or, in the case of nonprofit hospital and medical service associations, in one or more policies issued in conjunction with another). Such standards shall not require coverage in excess of coverage of the

Part A medicare deductible and the following coverage required under Section 7(I)(2) of the NAIC Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act; adopted by the National Association of Insurance Commissioners on June 6, 1979:

(A) coverage on the Part A coinsurance for the 61th day through the 90th day of inpatient hospital services in any medicare benefit period;

(B) coverage of Part A coinsurance for medicare's lifetime hospital inpatient reserve days;

(C) coverage of 90 percent of all medicare Part A eligible expenses for hospitalization not covered by medicare after the beneficiary has exhausted all inpatient coverage including lifetime reserve days, subject to a lifetime maximum benefit of an additional 365 days; and

(D) coverage of 20 percent of the amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket deductible of $200 of such expenses and to a maximum benefit of at least $5,000 per calendar year;

(2) The policy must be written in simplified language and in a form which can be easily understood by purchasers;

(3) It does not limit or preclude liability under the policy for a period longer than six months because of a pre-existing health condition;

(4) It contains a prominently displayed "no loss cancellation clause" enabling the insured to return the policy within 30 days of the date of receipt of the policy (or the certificate issued thereunder) with return in full of any premium paid.

(5) It can be expected (as estimated for such period, not to exceed one year, to the maximum extent appropriate, on the basis of actual claims experience and premiums for such policy and in accordance with accepted actuarial principles and practices) to return to policyholders in the form of aggregate benefits provided under the policy, at least such percentage of the aggregate amount of premiums collected as the Secretary finds reasonable (taking into account all relevant underwriting and other considerations relating to the design and marketing of such policies) for all group policies and, separately, for all individual policies. The estimate, to the maximum extent appropriate, should be on the basis of actual claims experience and premiums for such policy and in accordance with accepted actuarial principles and practices.

(6) It contains a written statement, in such form as the Secretary may prescribe, for prospective purchasers of such information as the Secretary shall prescribe relating to:

(A) the policy's premium, coverage in relation to the coverage and exclusions under Medicare, and renewability provisions; and

(B) the identification of the insurer and its agents.

New Section 1882(d)(1) provides that it is a felony to knowingly make or cause to be made or induce or seek to induce the making of any false statement or representation of a material fact with respect to the

compliance of any policy with the minimum standards set forth in new Section 1882(c) or in regulations promulgated pursuant to such subsection, or with respect to the use of the certification emblem. A person convicted of such action shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

New Section 1882(d)(2) provides that it is a felony to falsely assume or pretend to be acting, or misrepresent in any way that one is acting under the authority of or in association with the Medicare program or any Federal agency, for the purpose of selling or attempting to sell insurance. The section further provides that it is a felony as such a pretended character to demand, or obtain money, paper, documents, or anything of value. A person convicted of such action shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

New Section 1882(d)(3) provides that it is a felony to knowingly sell a health insurance policy to an individual entitled to benefits under Medicare Part A or enrolled under Medicare Part B, with knowledge that such policy substantially duplicates health benefits to which such individual is otherwise entitled, other than benefits to which he is entitled under a requirement of State or Federal law (other than Medicare). A person convicted of selling duplicative policies shall be fined not more than $25,000 or imprisoned not more than five years. Benefits which are payable to or on behalf of an individual without regard to other health benefit coverage of such individual, shall not be considered as duplicative for purposes of this new Section 1882(d)(3). Further, Section 1882(d)(3) shall not apply with respect to the selling of a group policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations.

New Section 1882(d)(4) provides that whoever knowingly, directly or through his agent, mails or causes to be mailed any matter for a prohibited purpose shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both. A prohibited purpose is defined as the advertising, solicitation, or offer for sale of a Medicare supplemental policy (or a certificate issued thereunder), or the delivery of such a policy (or a certificate issued thereunder) into any State in which such policy or certificate has not been approved by the State commissioner or superintendent of insurance. Any Medicare supplemental policy (or a certificate issued thereunder) shall be deemed to be approved by the State commissioner or superintendent of insurance of such State if: 1) it has been approved by the commissioners or superintendents of insurance in the States in which more than 30 percent of such policies or certificates are sold; or 2) such State has in effect a law which the commissioner or superintendent of insurance has determined gives him the authority to review, and to approve, or effectively bar from sale in the State, such policy or certificate; except that such a policy or certificate shall not be deemed to be approved by a State

commissioner or superintendent of insurance if such State requests to the Secretary that such policy or certificate be subject to such State's approval. New Section 1882(d)(4) shall not apply in the case of a person who mails or causes to be mailed a Medicare supplemental policy (or certificate issued thereunder) into a State if such person has ascertained that the party insured under such policy to whom (or on whose behalf) such policy or certificate is mailed is located in such State on a temporary basis. Further, new Section 1882(d)(4) shall not apply in the case of a person who mails or causes to be mailed a duplicate copy of a Medicare supplemental policy (or of a certificate issued thereunder) previously issued to the party to whom (or on whose behalf) such duplicate copy is mailed, if such policy or certificate expires not more than 12 months after the date on which the duplicate copy is mailed.

New Section 1882(e) requires the Secretary to provide to all individuals entitled to benefits under Medicare (and to the extent feasible, individuals about to become so entitled) such information as will permit them to evaluate the value of Medicare supplemental policies to them and the relationship of any such policies to Medicare benefits.

New Section 1882(f)(1) requires the Secretary, in consultation with Federal and State regulatory agencies, the National Association of Insurance Commissioners, private insurers, and organizations representing consumers and the aged to conduct a comprehensive study and evaluation of the comparative effectiveness of various State approaches to the regulation of Medicare supplemental policies in the following areas:

(1) limiting marketing and agent abuse;

(2) assuring the dissemination of such information to individuals entitled to Medicare benefits (and to other consumers) as is necessary to permit informed choice;

(3) promoting policies which provide reasonable economic benefits for such individuals;

(4) reducing the purchase of unnecessary duplicative coverage;

(5) improving price competition; and

(6) establishing effective State regulatory control programs.

The study shall also address the need for standards or certification of health insurance policies (other than Medicare supplemental policies) sold to individuals eligible for Medicare benefits. The Secretary is required to submit a report to the Congress no later than July 1, 1981, on the results of the study together with such recommendations as he finds warranted with respect to the need for legislative or administrative changes to accomplish the specified objectives. The report shall include recommendations pertaining to the need for a mandatory Federal regulatory program to assure the marketing of appropriate types of Medicare supplemental policies, and such other means as he finds may be appropriate to enhance effective State regulation of such policies.

New Section 1882(f)(2) requires the Secretary to submit to the Congress on January 1, 1982, and periodically as may be appropriate thereafter (but not less than every two years), a report evaluating the effectiveness of the certification procedure and the criminal penalties

established under the new Section 1882. Such reports shall include an analysis of:

(A) the impact of such procedure and penalties on the types, market share, value, and cost to Medicare beneficiaries of Medicare supplemental policies which have been certified by the Secretary;

(B) the need for any changes in the certification procedure to improve its administrative or effectiveness; and

(C) whether the certification program and criminal penalties should be continued.

New Section 1882(g) defines a Medicare supplemental policy, for purposes of Section 1882 as a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under Medicare which provides reimbursement for expenses incurred for services and items for which payment may be made under Medicare but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed under the program. A Medicare supplemental policy does not include any such policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations.

New Section 1882(A) requires the Secretary to prescribe such regulations as may be necessary for the effective, efficient, and equitable administration of the new certification procedure.

New Section 22(a)(2) provides that the new Section 1882 of the Social Security Act shall become effective on the date of the enactment of the bill except that the provisions of Section 1882(d)(4) of the Act (relating to felony penalties for persons guilty of mailing prohibitive material) shall become effective on January 1, 1982.

Section 22(a)(3) requires the Secretary to issue final regulations to implement the certification procedure not later than October 1, 1980. No policy shall be certified and no policy may be issued bearing the emblem authorized by the Secretary until January 1, 1982. On and after January 1, 1982, policies certified by the Secretary may bear such emblem, including policies which were issued prior to January 1, 1982, and were subsequently certified; insurers may notify holders of such certified policies issued prior to January 1, 1982, using such emblem in the notification.

Section 22(b) amends Section 1877 of the Social Security Act pertaining to Medicare penalties by adding a new subsection (e). The new subsection (e) provides that whoever falsely assumes or pretends to be acting, or misrepresents in any way that he is acting under the authority of or in association with the Medicare program for the purpose of selling or attempting to sell insurance, or in such pretended character demands, or obtains money, paper, documents, or anything of value, shall be fined not more than $25,000, imprisoned not more than five years, or both. The penalty also applies to a person who knowingly permits another person to take such an action or make such a representation on his behalf.

Section 22(c) amends Section 1882(d)(4)(B)(i), as added by Section 22(a), which pertains to the prohibition against mailing advertisements, policies or related material into a State without approval of the State commissioner or superintendent of insurance. Section 22(c) specifies that in addition to the other conditions under which a policy shall be deemed to be approved, it shall be deemed to be approved if approved by the Secretary.

Section 23. Demonstration projects relating to the training of AFDC recipients as home health aides

Section 23(a) permits the Secretary to enter into agreements with States, selected at his discretion, for the purpose of conducting demonstration projects for the training and employment of eligible participants as homemakers or home health aides, who are to provide authorized services to elderly or disabled individuals, or other needy individuals.

Section 23(b) defines for purposes of this section the term "eligible participant" as an individual who has voluntarily applied for participation and who, at the time such individual enters the demonstration project, has been eligible for financial assistance under a State plan approved under Part A of title IV of the Social Security Act and has continuously received such financial assistance during the immediately preceding 90-day period and who, within such 90-day period, had not been employed as a homemaker or home health aide.

Section 23(c)(1) requires the Secretary to enter into agreements under section 23 with no more than 12 States and requires that priority be given to States which have demonstrated interest in providing such homemaker or home health aid services.

Section 23(c)(2) permits a State to apply to enter into an agreement under section 23 in such manner and at such time as the Secretary prescribe.

Section 23(c)(3) requires any State entering into an agreement with the Secretary under section 23 to:

(*a*) provide that the demonstration project be administered by a State health services agency designated for this purpose by the Governor;

(*b*) provide that the agency so designated must arrange for coordinating its activities under the agreement with activities of other State agencies having related responsibilities;

(*c*) establish a formal training program, which meets such standards as the Secretary may establish, to assure the adequacy of such program to prepare eligible participants to provide part-time and intermittent services to individuals who are elderly, disabled, or otherwise in need of such services;

(*d*) provide for the full-time employment of those eligible participants who successfully complete the training program with one or more public agencies (or, by contract, with private bona fide nonprofit agencies) as homemakers or home health aides rendering authorized services under appropriate supervision at wage levels comparable to the prevailing wage levels in the area for similar work;

(*e*) provide that such services must be made available without regard to income of the individual requiring such services, but

that a reasonable fee will be charged for services provided to individuals who have income in excess of 200 percent of the needs standard in the State under the State plan approved under Part A of title IV of the Social Security Act for a household of the same size as the individual's household;

(*f*) provide for a system of continuing independent professional review by an appropriate panel to assure that services are provided only to individuals reasonably determined to be in need of such supportive services;

(*g*) provide for evaluation of the project and review of all agencies providing services under the project;

(*h*) submit periodic reports to the Secretary as he may require; and

(*i*) meet such other requirements as the Secretary may establish for the proper and efficient implementation of the project.

Section 23(c)(4) provides that the number of participants in any project must not exceed that number which the Secretary determines to be reasonable, based upon the capability of the agencies involved.

Section 23(c)(5) requires any contract with a private bona fide nonprofit agency entered into to provide a training program under the project must provide for reasonable reimbursement of such agencies for services.

Section 23(c)(6) specifies, for purposes of section 23, that a facility of the Veterans' Administration must, at the request of the Administrator of Veterans' Affairs, be considered to be a public agency. In the case of any such facility, of the costs determined under section 23 which are attributable to such facility, 90 percent must be paid by the State and 10 percent by the Veterans' Administration.

Section 23(d)(1) defines authorized homemaker and home health aide services to include part-time or intermittent—

(*a*) personal care;

(*b*) assisting patients having limited mobility;

(*c*) feeding and diet assistance;

(*d*) home management, housekeeping, and shopping;

(*e*) health-oriented record keeping;

(*f*) family planning services; and

(*g*) simple procedures for identifying potential health problems.

Section 23(d)(2) specifies that such authorized services do not include any services performed in an institution, or any services more efficiently provided in an institution.

Section 23(e)(1) requires the Secretary to pay, under agreements entered into under section 23 with the State agency designated by the Governor, 90 percent of the reasonable cost incurred (less the Federal share of any related fees collected) by such State in carrying out the demonstration project.

Section 23(e)(2) limits the demonstration projects to a maximum duration of 4 years, plus an additional period of up to 6 months for planning and development, and up to 6 months for final evaluation and reporting and prohibits Federal funding for the employment of any eligible participant under the project after such participant has been employed for a period of 3 years.

Section 23(f) provides that for purposes of title IV of the Social Security Act, any eligible participant taking part in a training program under such a project is to be participating in a work incentive program established by Part C of such title.

Section 23(g) continues the eligibility of eligible participants employed in the demonstration project for medical assistance under title XIX of the Social Security Act, and any eligiblity for social and supportive services provided under Part A of title IV of such Act, for the first year (and such succeeding period as the State may specify) of such employment.

Section 23(h) requires the Secretary to submit annual reports to the Congress evaluating the demonstration projects carried out under section 23 and a final report to the Congress not less than 6 months after he has received the final reports from all States participating in such projects.

Section 23(i) authorizes the Secretary to waive such requirements, including formal solicitation and approval requirements, as will further expeditious and effective implementation of these provisions.

Section 24. Reimbursement for health maintenance organizations

Section 24(a) revises the provisions of Section 1876 of the Social Security Act, entitled "Payments to Health Maintenance Organizations."

Subsection (a) of revised Section 1876 requires the Secretary to determine annually a per capita payment rate for each class (based on factors such as age, sex, institutional status, disability status, and place of residence) of Medicare beneficiaries equal to 95 percent of the adjusted average per capita cost for that class. The term "adjusted average per capita cost" is defined as the average per capita amount that the Secretary estimates in advance would be payable in any contract year for covered services if the services were to be furnished by other than a health maintenance organization.

The Secretary is required to make advance monthly payments from the appropriate trust funds in accordance with the established rate to a health maintenance organization for Medicare enrollees.

Subsection (b) of revised Section 1876 defines, for Medicare purposes, the term "health maintenance organization" as a public or private organization, under the laws of any State which is either a qualified HMO (as defined in Section 1310(d) of the Public Health Service Act) or meets the following requirements:

(A) provides or otherwise makes available to enrolled participants health care services, including at least physicians' services, inpatient hospital services, laboratory, X-ray, emergency, and preventive services, and out of area coverage;

(B) is compensated (except for deductibles coinsurance, and copayments) for the provision of health care services to enrolled participants by a fixed periodic payment;

(C) provides physicians' services primarily either directly through physicians who are either employees or partners of such organization, or through arrangements with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis);

(D) assumes full financial risk on a prospective basis for the provision of the required health care services except that an HMO may obtain insurance or make other arrangements for: (1) the cost of providing to any enrollee required health care services the aggregate value of which exceeds $5,000 in any year; (2) the cost of required health care services provided other than by the HMO in an emergency, and (3) not more than 90 percent of the amount by which its costs for any year exceed 115 percent of its income for such year;

(E) has made provision, satisfactory to the Secretary, against risk of insolvency.

Revised Section 1876(b)(2) provides that the Secretary may not contract with an HMO under Medicare unless certain requirements are met. The HMO must provide only covered Medicare services to those covered under Parts A and B or just Part B except that additional services may be provided if the Secretary approves or the individual so elects. The Secretary shall approve additional services unless he determines it will discourage enrollment. The amount of deductibles, coinsurance, and copayments cannot exceed limits specified under the revised Section 1876(g). The HMO must provide services only through qualified providers, assure the availability and accessibility of services, provide for meaningful grievance procedures, and have arrangements for an ongoing quality assurance program. The HMO is required to have an open enrollment period of reasonable duration at least every year during which it accepts, up to the limits of its capacity and without restrictions (except as authorized in regulations), individuals who are eligible to enroll under revised Section 1876(d) in the order in which they apply for enrollment, unless to do so would result in failure to meet the requirements of revised Section 1876(h) or would result in the enrollment of enrollees substantially nonrepresentative of the population in the geographic area served by the HMO. Further the HMO must provide assurances to the Secretary that it will not expel or refuse to reenroll any individual because of his health status or requirements for health services, and it must notify each individual of such fact at the time of his enrollment.

Subsection (c) of revised Section 1876 provides that if an individual is enrolled in accordance with this Section 1876 with a health maintenance organization, only the health maintenance organization is entitled to receive Medicare payments for services furnished to the individual.

Subsection (d) of revised Section 1876 establishes the eligibility of every individual entitled to benefits under Part A and enrolled under Part B or enrolled under Part B only (other than an individual medically determined to have end-stage renal disease) to enroll under Section 1876 with any health maintenance organization which has a contract with the Secretary and which sreves the geographic area in which the individual resides.

Subsection (e) of revised Section 1876 permits an enrolled individual to terminate his enrollment with the health maintenance organization as of the beginning of the first calendar month following a full calendar month after the request for termination is made, and authorizes the Secretary to prescribe procedures related to enrollment and the dissemination of information to beneficiaries.

Subsection (f) of revised Section 1876 specifies the right of a beneficiary who believes he has been underserved or overcharged by the health maintenance organization to a hearing before the Secretary if the amount in controversy is $100 or more. Beneficiaries and health maintenance organizations are entitled to judicial review of the Secretary's determination if the amount in controversy is $1,000 or more.

Subsection (g) (1) of revised Section 1876 prohibits health maintenance organizations from charging beneficiaries more than the actuarial value of the Medicare deductibles and coinsurance for services covered under Medicare.

Subsection (g) (2) of revised Section 1876 requires the election by enrolled beneficiaries of coverage additional to that provided by Medicare to be optional (unless the Secretary has approved additional services under revised Section 1876(b)(2)(A)) and specifies that the charge to beneficiaries for such additional coverage cannot exceed the adjusted community rate for the services.

Subsection (g) (3) of revised Section 1876 defines, for purposes of section 1876, the term "adjusted community rate" for a service as either (at the election of the HMO) : 1) the rate of payment for that service which the Secretary annually estimates would apply to a beneficiary enrolled with a health maintenance organization if the rate of payment were determined under a "community rating system" (as defined in Section 1302(8) of the Public Health Service Act, other than subparagraph (C); or 2) the portion of the weighted aggregate premium which the Secretary annually estimates would apply to an enrolled individual as is distributable to payment for that service. In both cases the rate shall be adjusted to account for differences between the utilization characteristics of beneficiaries and those of the other members of the organization.

Subsection (g) (4) of revised Section 1876 permits the health maintenance organization to have an enrolled membership at least half is entitled to benefits under a workmen's compensation law or under an automobile insurance policy) to charge—

(*a*) the insurance carrier, employer, or other entity which under such law or policy is to pay for the provisions of such services, or

(*b*) the beneficiary to the extent that he has been paid under such law or policy for such services.

Subsection (h) of revised Section 1876 requires the health maintenance organization to have an enrolled membership at least half of which consists of individuals who are entitled to benefits under title XVIII or title XIX. The Secretary is permitted to modify or waive this requirement in circumstances that warrant special consideration provided that the health maintenance organization will not have, for the duration of its contract, an enrolled membership of which one-half or more are individuals entitled to benefits under title XVIII.

Subsection (i) (1) of revised Section 1876 permits the Secretary to enter into a contract with any health maintenance organization that meets the definition contained in subsection (b) (1) of revised Section 1876.

Subsection (i) (2) of revised Section 1876 requires each contract with a health maintenance organization to provide that if the ad-

justed community rate for enrolled individuals with Medicare coverage (Parts A and B or Part B only) is less than the average per capita rates of payment made under Section 1876 at the beginning of the contract period, the organization must provide to such enrollees additional benefits which are selected by the organization. These additional benefits must equal or exceed the value of the difference between the average per capita payment and the adjusted community rate.

Subsection (i)(3) of revised Section 1876 requires these additional benefits to be either (A) the reduction of the premium rate or other charges made with respect to services furnished by the organization to individuals enrolled under Section 1876, or (B) the provision of additional benefits or both.

Subsection (i)(4) of revised Section 1876 requires the effective date of any contract to be specified in the contract.

Subsection (i)(5) of revised Section 1876 requires each contract to include certain provisions relating to (A) the right of the Secretary to evaluate the services provided by the health maintenance organization and to inspect the organization's books and records; (B) notification to beneficiaries of contract termination; and (C) compliance with other terms and conditions the Secretary may find necessary.

Subsection (i)(6) of revised Section 1876 prohibits the Secretary, except under special circumstances, from contracting with a health maintenance organization under Section 1876 if the organization had, within the last five years, requested the termination of a previous Section 1876 contract.

Subsection (i)(7) of the revised Section 1876 provides that the contract authority granted to the Secretary under subsection (i) may be exercised without regard to conflicting provisions of law or regulations relating to the making, performance, amendment, or modification of contracts to the United States.

Section 24(b) of the bill amends Section 1861(s)(2) of the Social Security Act by adding a new subparagraph (G), which covers under Part B services furnished by a physician assistant or nurse practitioner to beneficiaries enrolled in a health maintenance organization with a contract under Section 1876.

Section 24(c)(1) of the bill amends Section 1861 of the Social Security Act to make technical conforming changes to the definition of the terms "physician assistant" and "nurse practitioner."

Section 214(c)(2) amends Section 3(e) of P.L. 95–210 to make a conforming change.

Section 24(d)(1) amends Section 1122 of the Social Security Act to add a new Subsection (j). New subsection (j) exempts from review under Section 1122 of the Social Security Act any capital expenditure made by or on behalf of a health care facility that would be exempted from certificate of need review under Section 1527 of the Public Health Service Act.

Section 24(d)(2) amends Section 1124(a)(2)(A) of the Social Security Act to make a conforming change.

Section 24(e) provides that the amendments made by Section 24 (except subsections (c) and (d)) shall generally apply to services furnished on or after the first day of the thirteenth calendar month

which begins after the date of enactment of the bill, or earlier if a health maintenance organization so requests and the Secretary agrees. These amendments do not apply to beneficiaries who are enrolled with a health maintenance organization at the time it enters into a contract under revised Section 1876 unless they request otherwise or the Secretary, because of the administrative costs or other burdens involved, requires the amendments to be applied. The amendments also do not apply (unless the organization requests otherwise) for five years following enactment in the case of a health maintenance organization which had a risk-sharing contract with the Secretary under the existing provisions of Section 1876 immediately before the date of enactment.

Section 24(f) of the bill requires the Secretary to conduct a study of the additional benefits selected by health maintenance organizations pursuant to Section 1876(i)(2) of the Social Security Act, as added by Section 24(a) of the bill. The Secretary is required to report to the Congress within 24 months of the date of the enactment of the bill with respect to the findings and conclusions made as a result of the study.

Section 24(g) requires the Secretary to conduct a study evaluating the extent of, and reasons for, the termination by Medicare beneficiaries of their membership in health maintenance organizations. The Secretary is required to submit an interim report to the Congress within two years of the date of the enactment of the bill, and a final report within five years of the date of enactment containing findings and conclusions made as a result of the study.

Section 25. Quality assurance programs for clinical laboratories

Section 25(a) amends Title XI of the Social Security Act by adding a new Section 1129 entitled "Quality Assurance Programs for Clinical Laboratories."

New Section 1129 requires the Secretary of HEW, in any regulations issued relating to the quality of diagnostic tests performed in hospitals and independent laboratories participating in Medicare and medicaid—

(1) only impose such requirements, in addition to those provided for by State or local law, as are found necessary to correct deficiencies;

(2) employ, consistent with adequate standards of quality assurance, quality assurance methods designed to result in the least imposition of costs and the fewest restrictions on personnel performing or supervising the tests; and

(3) employ, to the extent feasible methods which take into account and are appropriate to difference types of laboratories.

Section 25(b) provides that the amendment made by Section 25 shall not be construed to require the Secretary to modify or repeal any regulations in effect on January 1, 1980.

Section 26. Reimbursement of clinical laboratories under medicare and medicaid

Section 26(a)(1) amends Ssection 1842 of the Social Security Act by adding a new subsection (h). The new subsection (h) establishes certain limits on reimbursement for laboratory tests billed by physi-

cians. New subsection h(1) provides that payment shall be the reasonable charge for the service (less the applicable deductible and coinsurance amounts) if the bill or request for payment indicates that the physician who submitted the bill or for whose services the request for payment was made personally performed or supervised the performance of the test or that another physician with whom the physician shares his practice personally performed or supervised the test. New subsection h(2) provides that if the physician's bill or request for payment indicates the test was performed by a laboratory, identifies the laboratory and the amount charged, the payment (less applicable deductible and coinsurance amounts) shall be the lower of the laboratory's reasonable charge to Part B enrollees for the test or the amount the laboratory charged the physician. In addition, payment may include a nominal fee (where the physician bills for such service) to cover the physician's costs in handling the sample. New subsection h(3) provides that payment shall be the lowest charge at which the carrier estimates the test could have been secured by a physician from a laboratory serving the locality (less applicable deductible and coinsurance amounts) if the bill or request for payment: (A) does not indicate who performed the test, or (B) indicates that the test was performed by a laboratory but does not identify the laboratory or include the amount charged by the laboratory.

Section 26(a)(2) specifies that the amendments made by subsection 26(a)(1) shall apply to bills submitted and requests for payments made on or after the date the Secretary of HEW prescribes in a notice in the Federal Register but no later than July 1, 1980.

Section 26(a)(3) requires the Secretary to report to the Congress within 24 months of the effective date specified in Section 26(a)(2) on: (A) the proportion of bills and requests for payments submitted (during the eighteen-month period beginning on such effective date) under title XVIII for laboratory tests which did not identify who performed the tests; (B) the proportion of bills and requests for payment submitted during such period for laboratory tests with respect to which the amount paid was less than the amount that would otherwise have been payable in the absence of the new Section 1842(h); (C) with respect to requests for payment which were submitted by patients, the average additional cost per laboratory test to patients resulting from reductions in payment that would otherwise have been made for such tests in the absence of new section 1842(h), and (D) with respect to bills which were submitted by physicians, the average reduction in payments per laboratory test to physicians resulting from the application of new Section 1842(h).

Section 26(b)(1) amends section 1902(a) of the Social Security Act relating to State plan requirements for Medicaid by adding a new paragraph 42. The new paragraph 42 provides that if the State plan makes provision for payment to a physician for laboratory services which such physician (or any other physician with whom he shares his practice) did not personally perform or supervise, the plan must insure that payment for such laboratory services not exceed the payment authorized for such services by the new Section 1842(h).

Section 26(b)(2)(A) provides that the amendments made by Section 26(b)(1) shall (except where State legislation is required) apply

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to medical assistance provided under a State plan on and after the first calendar quarter that begins more than six months after the date of enactment. Section 26(b)(2)(B) provides that where the Secretary determines that State legislation is required in order for the plan to meet the additional requirements imposed by Section 26(b)(1), the State plan shall not be regarded as failing to comply with the requirements of Title XIX of the Social Security Act solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this bill.

Section 26(c)(1)(A) amends Section 1902(a)(23) of the Social Security Act pertaining to freedom of choice requirements under Medicaid by adding a new subparagraph (B). The new subparagraph (B) allows States to purchase laboratory services covered under their State plans through a competitive bidding process or otherwise for a three-year period beginning on the date of enactment. Such purchase arrangements can be made if the Secretary has found that: (1) adequate service will be available under such arrangements; (2) such laboratory services will be provided only through laboratories which meet the health, safety and other requirements of Section 1861(e)(9) or paragraphs (10) and (11) of Section 1861(s) of the Social Security Act, and such additional requirements as the Secretary may require; (3) no more than 75 percent of the laboratories' charges for such services are for services provided to individuals who are entitled to benefits under Medicaid or Medicare and (4) charges for services provided under such arrangements are made at the lowest rate charged (determined without regard to administrative costs which are related solely to the method of reimbursement for such services) for comparable services by the provider of such services, or, if charged for on a unit price basis, such charges result in aggregate expenditures not in excess of expenditures that would be made if charges were at the lowest rate charged for comparable services by the provider of such services.

Section 26(c)(1)(B) requires the Secretary to evaluate the arrangements made for purchase of laboratory services under the new Section 1902(a)(23)(B) of the Act and transmit that evaluation to the Congress within 24 months of enactment together with recommendations as to whether such section should be extended or modified.

Section 26(c)(2) amends Section 1902(a)(9) by adding a new subparagraph (C). New subparagraph (C) provides that laboratory services must be provided by laboratories meeting requirements for participation under Medicare as specified in Section 1861(e)(9) or paragraphs (10) and (11) of Section 1861(s) of the Social Security Act.

Section 27. Reimbursement of physicians' services in teaching hospitals

Section 27(a)(1) amends Section 1861(b)(7) by providing that the term inpatient hospital services includes services rendered by a supervisory physician where the hospital has an approved teaching program if: (A) the hospital elects to receive any payment due on a reasonable cost basis for such services and (B) all physicians in such hospital agree not to bill chargs for professional services rendered in such hospital to Medicare patients.

Section 27(a)(2) amends Section 1832(a)(2)(B)(i)(II) of the Social Security Act to make a conforming change.

Section 27(b) provides that the amendments made by Section 27(a) shall apply with respect to cost accounting periods beginning on or after October 1, 1978. Section 27(b) also provides that a hospital's election to receive reasonable cost reimbursement for supervisory physicians under the provisions of Section 1861(b)(7)(A) of the Social Security Act (as administered in accordance with Section 15 of Public Law 93–233) as of September 30, 1978, shall constitute such hospital's election under such section (as amended by this Act) on and after October 1, 1978, until the hospital provides otherwise.

Section 28. Reimbursement under medicaid for services furnished by nurse-midwives

Section 28(a)(1) amends Section 1905(a) of the Social Security Act by adding a new paragraph 17. The new paragraph adds services furnished by a nurse midwife to the list of Medicaid services. Such services are those which a nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not he is under the supervision of, or associated with, a physician or other health care provider.

Section 28(a)(2) amends Section 1905 by adding a new subsection (n). The new subsection (n) defines the term "nurse-midwife" as a registered nurse who has successfully completed a program of study and clinical experience meeting guidelines prescribed by the Secretary, or has been certified by an organization recognized by the Secretary, and performs services in the area of management of the care of mothers and babies (throughout the maternity cycle) which he is legally authorized to perform in the State in which he performs such services.

Section 28(b) amends Section 1902(a)(13) of the Social Security Act by adding nurse-midwife services to the list of mandatory Medicaid services and make other conforming changes.

Section 28(c)(1) provides that the amendments made by Section 28 shall (except where State legislation is required, be effective with respect to Medicaid payments for calendar quarters beginning more than one hundred and twenty days after the date of enactment of this bill. Section 28(c)(2) provides that where the Secretary determines that State legislation is required in order for the plan to meet the additional requirements, the State plan shall not be regarded as failing to comply with the requirement of Title XIX of the Social Security Act solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this bill.

Section 29. Extended medicaid coverage for the severely medically impaired

Section 29(a)(1) amends Section 1902 of the Social Security Act by adding a new subsection (i). The new subsection (i) states that for purposes of Medicaid a disabled individual shall continue to be treated as categorically-related during the period following his trial work period (as provided under the Social Security Income Disability

Amendments of 1979) that he retains his disability status but is not receiving Supplemental Security Income payments. An individual shall also be treated as categorically-related if he is determined (in accordance with standards established by the Secretary) to: (A) have a severe medical disability and to meet except for earnings all non-disability related requirements of SSI; (B) have an income, except for earnings which does not exceed the SSI income standard; (C) have been receiving medical assistance as categorically needy, be otherwise subject to termination of such assistance which would seriously inhibit his ability to continue employment; and (D) have earnings which are insufficient to allow him to provide for himself a reasonable equivalent of the benefits which would, in the absence of such earnings, be available to him under Medicaid and SSI. The new subsection (i) further specifies that an individual shall be considered to have a severe medical disability if his impairment is sufficiently severe to result in a functional limitation requiring medical assistance in order for him to work.

Section 29(a)(2) further amends Section 1902(a)(10) of the Act by providing that the making available of medical assistance under the new Section 1902(i) shall not by reason of Section 1902(a)(10) require the making available of services of the same amount, duration, and scope, to any other individual.

Section 29(b) amends Section 1902(a)(17) by adding a new clause E. The new clause E requires States in making medically needy eligibility determinations to disregard certain amounts of earned income (as specified under Section 1612(b)(iv)(B)(ii)—(iv) as added by the Supplemental Security Income Disability Amendments of 1979) with respect to individuals who have disabilities which are sufficiently severe to result in functional limitations requiring medical assistance in order that they may work.

Section 29(c) adds a new clause (vii) to Section 1905(a) which makes conforming changes.

Section 29(d) provides that the amendments made by this Section 25 shall, except where State legislation is required apply to medical assistance to be provided under State Medicaid plans, on or after the first day of the first calendar quarter that begins more than six months after the date of the enactment of this Act. Where the Secretary determines that State legislation is required, the State plan shall not be regarded as failing to comply with the requirements of Title XIX of the Social Security Act solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

Section 30. Continuing medicaid eligibility for certain individuals by disregarding certain involuntary increases in income

Section 30 amends Section 1902(a) of the Social Security Act by adding a new sentence. The new sentence requires States in determining the continuing eligibility of Medicaid recipients to exclude from the calculation of an individual's income any cost-of-living or price index increase or annual general increase in Social Security, Railroad Retirement, Veterans or Civil Service benefits, annuities, pensions or other

compensation. The new sentence applies with respect to individuals determined eligible for Medicaid in a month after May 1980 who would otherwise become ineligible in a subsequent month because of such increase. Their eligibility will continue until the first month in which they otherwise become ineligible.

Section 31. Limitation on medicaid eligibility for individuals who dispose of resources

Section 31(a)(1) amends Section 1902(a)(17)(B) of the Social Security Act by providing that the new Section 1902(j) of the Act is an exception to the provision regarding determination of income eligibility for the medically needy.

Section 31(a)(2) adds a new Section 1902(j) to the Social Security Act.

The new Section 1902(j)(1) permits a State to defer Medicaid eligibility for a specified period (notwithstanding the other provisions of Title XIX of the Social Security Act except for the new Section 1902(j)(2) and 1902(j)(4)) if an individual disposed of his resources within a specified period. States may defer eligibility if within two years preceding application for Medicaid coverage an indivdual (or other person whose resources are considered in determining his eligibility) had disposed of resources with an uncompensated value of $6,000 or more (which if retained would have made him ineligible) in order to establish Medicaid eligibility. The section provides that any disposition of resources within the specified period may be presumed to be for such purpose unless the State is furnished convincing evidence that the transaction was for some other purpose. The section further provides that uncompensated value is the sum of: (1) the current market value of the individual's (or other person's) equity interest in such resources disposed of without any compensation; and (2) the difference between the current market value of the individual's (or person's) equity interest in such resources disposed of for compensation and the amount of such compensation.

The new Section 1902(j)(2)(A) provides that (except as provided in the new subparagraph B) a State may defer eligibility for six months if the uncompensated amount of disposed resources is less than $12,000 for 12 months if the amount is between $12,000 and $30,000, and 24 months if exceeded $30,000. The period of deferred eligibility begins the month following the month the disposition occurred.

The new Section 1902(j)(2)(B) provides that a period of ineligibility shall end after the month in which the individual (or other person) either: (1) returns the resources, the disposition of which caused the ineligibility to occur; or (2) receives payment equal to the amount of any uncompensated equity interest.

The new Section 1902(j)(2)(C) provides that a State plan may provide for the waiver of requirements of new Section 1902(j)(1) or a reduction in the period of ineligibility in cases where the State determines such action is justified.

The new Section 1902(j)(3) provides that if the eligibility of a person for medical assistance under Medicaid is dependent upon the eligibility of another individual and that other individual is deter-

mined to be ineligible for medical assistance under new Section 1902 (j)(1) for a period of time, the person shall be ineligible for the same period of time.

The new Section 1902(j)(4) provides that the deferral of eligibility shall not apply with respect to persons receiving supplemental security income benefits except in States which have employed more restrictive eligibility criteria pursuant to Section 1902(f) of the Social Security Act.

The new Section 1902(j)(5)(A) provides that if an individual disposes of resources to another person, which could make him ineligible under the new Section 1902(j), the State plan may provide for recovery from that person equal to either Medicaid payments made on behalf of the individual or to the person's equity interest in the resources for which compensation was not made, whichever is less. New Section 1902(j)(5)(A) further provides that a State may not initiate recovery action more than three years after the last date of the ineligibility period.

The new Section 1902(j)(5)(B) requires the State to notify the Secretary of amounts recovered, if any. The Secretary is required to reduce the amounts otherwise due to the State under Medicaid by an amount equal to the product of the amounts recovered and the Federal medical assistance percentage for that State.

Section 31(b)(1) provides that the new Section 1902(j), except as specified in Section 31(b)(2) shall become effective on the first day of the first month beginning after the date of enactment and shall apply to disposition of resources that occur (or occurred) on and after such date (before, on, or after the date of the enactment) as the State may specify.

Section 31(b)(2) provides that the new Section 1902(j)(5) of the Social Security Act shall apply to dispositions of property that occur on or after the date of the enactment of this Act.

Section 23. Adjustment of dollar limitation and elimination of special limitation on medicaid payments to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, American Samoa, and the Trust Territory of the Pacific Islands

Section 32(a)(1) amends Section 1101(a)(1) of the Social Security Act to extend Medicaid to Northern Mariana Islands, American Samoa, and the Trust Territory of the Pacific Islands.

Section 32(a)(2) amends Section 1108(c) of the Social Security Act to provide the following ceilings on Federal expenditures in FY 80: Puerto Rico—$60 million; Virgin Islands—$2 million; Guam—$1.8 million; Northern Mariana Islands—$250,000; American Samoa—$500,000; and Trust Territory of the Pacific Islands—$1.8 million. In subsequent fiscal years, payment to these areas may not exceed the FY 80 ceiling multiplied by a percentage equal to the percentage increase in the Consumer Price Index for all urban consumers (published monthly by the Bureau of Labor Statistics of the Department of Labor) between October 1980 and the first month of such fiscal year.

Section 32(b) amends Section 1905(b) of the Social Security Act to provide that the Federal matching rate is determined for the jurisdiction in the same manner as it is determined for the 50 States and

the District of Columbia. It strikes the provision of current law which sets a maximum on the Federal medical assistance percentage for the jurisdictions at 50 percent.

Section 32(c)(1) provides that the amendments made by subsection (a) shall apply to fiscal year 1980 and subsequent fiscal years.

Section 32(c)(2) provides that the amendments made subsequent (b) shall apply with respect to care and services provided, under a State Medical plan in a calendar quarter beginning after September 30, 1979. However, each of the agencies administering or supervising the administration of the State Medicaid plan for Puerto Rico, the Virgin Islands, Guam, or the Northern Mariana Islands may elect not to have the amendments made by subsection (b) apply to any care or services provided in its jurisdiction to an individual over a period of time beginning before October 1, 1979 and ending after October 1, 1979.

Section 33. Extensions of increased funding for long-term-care facility inspection under medicaid

Section 33(a) amends Section 249B of P.L. 92–603 (as amended by P.L. 93–368 and P.L. 95–83) to delete the termination date specified in that section for Section 1903(a)(4) of the Social Security Act.

Section 33(b) amends Section 1903(a)(4) of the Act to specify that 100 percent Federal matching for skilled nursing facility inspectors under Medicaid is available for calendar quarters ending prior to October 1, 1983. This is a three year extension over current law.

Section 33(c) provides that the amendment made by Section 33(b) shall apply to calendar quarters beginning on or after October 1, 1980.

Section 34. Extension of increased funding for State medicaid fraud control units

Section 34 amends Section 1903(a)(6) of the Social Security Act to provide that ninety percent Federal matching is available for State Medicaid fraud control units for three years (beginning with the first quarter such increased matching was available in the State). The section further provides that seventy-five percent Federal matching is available for State Medical fraud control units in subsequent calendar quarters.

Section 35. Medicaid payments to States (fund drawdown)

Section 35(a) amends Section 1903(d)(2) of the Social Security Act, pertaining to installment payments to the States, to require the Secretary to insure that payments to States are not made before the time that checks issued by the State for the medical assistance or other expenditure for which the Federal payment is being made are cleared through the State depository for payment. The Secretary shall provide that each State may, with his approval, designate an estimating procedure to use to determine the amount of the Federal payment. The amended Section 1903(d)(2) further provides that in any State which has in its Constitution a provision prohibiting the issue of checks or warrants by State officials unless there are funds in the State Treasury to pay for them, the Secretary shall reduce the amount of payment otherwise obligated to be made to the State under Medicaid by an amount equal to the amount of the interest on Federal funds held by

the State in the period of time before the time the check or warrant is cleared through the State depository for payment. Such amount of interest shall be determined each calendar quarter and shall be based on the average of the bond equivalent of the weekly 90-day Treasury bill auction rates for the four most recent weekly auctions preceding the beginning of the quarter, less the reasonable cost of banking services.

Section 35(b) provides that the amendment made by Section 35(a) shall apply to payments made on and after a date the Secretary shall establish but no later than December 31, 1980 except where State legislation is required. If the Secretary determines that State legislation is required, the amendment shall not become effective with respect to payments made to that State until the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature which begins after the date of the enactment of the bill.

Section 36. Change in calendar quarter for which satisfactory utilization review must be shown to receive waiver of medicaid reduction

Section 36 amends Section 1903(g)(3)(B) of the Social Security Act to provide that the Secretary shall waive application of penalties for unsatisfactory utilization review showings under Medicaid for any calendar quarter of 1977 if the Secretary determines a satisfactory showing was made in any calendar quarter of 1978. It modifies the current law which provides that if the State is in compliance for the calendar quarter ending December 31, 1977 the Secretary shall waive penalties for the first three quarters occurring in 1977.

Section 37. Demonstration projects for requiring second opinions for certain elective surgical procedures under medicare and medicaid

Section 37(a)(1) adds a new Section 1130 to the Social Security Act entitled "Demonstration Projects for Requiring Second Opinions for Certain Elective Surgical Procedures Under Medicare and Medicaid."

New Section 1130(a)(1) authorizes the Secretary to make grants to, and enter into contracts with, public and private non-profit entities (including professional standards review organizations and medical societies) for the conduct of certain demonstration projects. Such projects are for the purpose of determining the cost-effectiveness and appropriateness of requiring that a second opinion with respect to specified elective surgical procedures (as defined in new subsection (f)(1)) be provided before payment may be made for such procedures under Medicare and Medicaid.

New Section 1130(a)(2) requires the Secretary to provide for: A) demonstration projects applicable to all specified elective surgical procedures proposed to be furnished to Medicare beneficiaries; and B) demonstration projects applicable to all specified elective surgical procedures proposed to be furnished to medicaid recipients.

New Section 1130(a)(3) requires the Secretary, to the extent feasible, to provide: A) for at least seven such demonstration projects; B) that the number of such projects conducted be equally divided between projects relating to services provided to Medicare beneficiaries and those provided to Medicaid recipients; and C) for the conduct of

such projects in a variety of geographic settings and covering a variety of sizes of populations, in order to determine the relative effectiveness of requiring second opinions in different areas of the country and under programs of different sizes.

New Section 1130(b)(1) specifies that no grant may be made or contract entered into for a demonstration project unless an application has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary may provide.

New Section 1130 (b)(2) provides that the amount of any grant or contract shall be determined by the Secretary.

New Section 1130(b)(3) provides that grants and payments under contracts made for demonstration projects and related administrative expenses (including expenses for analysis of data) for such projects relating to services provided to Medicare beneficiaries shall be made in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. For such projects relating to services provided to Medicaid recipients, payment shall be made from funds appropriated under the Medicaid program. New Section 1130(b)(3) further provides that grants and payments under contracts may be made either in advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as he finds necessary to carry out the stated purpose.

New Section 1130(b)(4) provides that in addition to any other authority assigned to professional standards review organizations, they are authorized to receive grants and enter into contracts for demonstration projects under this section.

New Section 1130(b)(5) authorizes an appropriation of up to $7 million for fiscal year 1981, to remain available until expended, for administrative expenses (incuding analysis of data) associated with the demonstration projects.

New Section 1130(c) specifies that no grant or contract shall be made for a demonstration project unless it meets the following requirements:

(1) The project must potentially apply to a sufficiently large population of individuals eligible for Medicare Part A benefits (in the case of projects relating to services provided Medicare beneficiaries) or for Medicaid services (in the case of a project relating to services provided Medicaid recipients) for specified elective surgical procedures recommended during a two-year period, so as to provide for statistically valid data to properly evaluate the project.

(2) The project must provide (through the entity or the Secretary) for notice to the applicable population, and, to the extent feasible, to physicians and hospitals which may proved specified elective surgical procedures for such population, of the existence of the demonstration project and the requirement for a second opinion as a condition of payment for such procedures. Further, the notice must include a general description of the procedure and techniques available for the treatment of the condition for which a specified elective surgical procedure has been recommended. The

project must also provide for making available to individuals covered under the project lists of qualified physicians who have indicated that they will provide, in accordance with the provisions of the project, written opinions with respect to the necessity and appropriateness of particular specified elective surgical procedures.

(3) To the extent practicable and consistent with the protection of patient privacy, the project must be so designed as to:

(A) prevent the qualified physician providing the second or third opinion from knowing the identity of the physician who provided a previous opinion with respect to that procedure; and

(B) avoid duplication of laboratory and other tests required in order to render such an opinion.

(4) The project must provide that interim data on the project's performance shall be transmitted to the Secretary not later than eighteen months after the date the project is initiated. Final data on its performance shall be transmitted not later than six months after the end of the two-year period.

New Section 1130(d)(1) provides that notwithstanding any other provision of law (except as provided in paragraph (2)), if a specified elective surgical procedure to be furnished to an individual is covered under a demonstration project, no payment may be made under Medicare or Medicaid with respect to the procedure unless the individual has been furnished, before the procedure is undertaken, at least:

(A) one written opinion by a physician meeting the requirements described in Section 1130(f)(2)(A); and

(B) one written opinion by a qualified physician (as defined in Section 1130(f)(2)) who meets these requirements and in addition agrees not to perform the surgical procedure (except in an emergency) and is not affiliated with the physician providing the previous opinion.

Such opinions shall be based on all factors deemed relevant to the determination, respecting the necessity and appropriateness of the procedure.

New Section 1130(d)(2) provides that second opinions shall not be required in the following circumstances:

(A) in the case of a Medicare-related demonstration project, to procedures furnished by or through a health maintenance organization under a risk sharing contract entered into with the Secretary pursuant to section 1876(i)(2)(A), or in the case of a Medicaid-related demonstration project to procedures by or through a health maintenance organization which provides to the enrollees, on a prepaid capitation risk basis or on any other risk basis, such procedures; and

(B) in the case in which the patient is unable, because of severe physical or cognitive limitations, to understand the requirement for second opinions or in such other cases as the Secretary determines are required by equity.

New Section 1130(e) requires the Secretary to analyze the data on demonstration projects transmitted to him and to submit to the Congress: (1) an interim report on the projects not later than two years

after the date of enactment and (2) a final report on the projects not later than four years after the date of enactment. The final report shall include recommendations, as the Secretary deems appropriate, for legislative changes with respect to imposing a second opinion requirement with respect to some or all of the specified elective surgical procedures.

New Section 1130(f)(1) provides that in the case of a demonstration project applicable to the Medicare program, specified elective surgical procedures are: cholycystectomy, menisectomy, prostatectomy, cataract surgery, hemorrhoidectomy, and excision of varicose veins. In the case of a demonstration project applicable to Medicaid, specified elective procedures are: hysterectomy, menisectomy, submucous resection, hemorrhoidectomy, excision of varicose veins, and tonsillectomy and adenoidectomy. Such procedures must be medically necessary to treat other than an emergency medical condition. In addition, the term elective surgical procedure includes such other elective surgical procedures as the Secretary, in his discretion, determines to be appropriate.

New Section 1130(f)(2) defines the term "qualified physician" to mean, with respect to an opinion on a specified elective surgical procedure for treatment of a medical condition of a particular patient, a physician who—

(A) is a board-eligible or certified specialist with respect to the procedure or with respect to treatment of the medical condition or who possesses such other qualifications with respect to such procedure or treatment as the Secretary may specify;

(B) agrees not to perform the surgical procedure for which the opinion is sought (except under emergency conditions); and

(C) is not affiliated with a physician who provided a previous opinion with respect to such treatment of such patient.

Section 37(a)(2) bars the Secretary of Health and Human Resources from making grants or entering into contracts under the new Section 1130 of the Social Security Act until October 1, 1980. Any projects under such grants or contracts shall be construed to be subject to any of the requirements of part 46 of title 45, Code of Federal Regulations (applicable to research, development, and related activities in which human subjects are involved).

Section 37(b)(1) amends Section 1861(q) of the Social Security Act to include consultation as to the necessity and appropriateness of elective surgical procedures within the definition of physicians services.

Section 37(b)(2) amends Section 1833(a)(1) of the Social Security Act by adding new paragraph (F). New paragraph (F) provides that payment for a second or third opinion as to necessity and appropriateness of specified elective surgical procedures under a Medicare demonstration project shall be equal to 100 percent of the reasonable charge for such opinion. In addition, the Part B deductible shall not be applicable with respect to such opinions.

Section 37(b)(3) amends Section 1842(b)(3)(B) of the Social Security Act to make a conforming change. The section further amends Section 1842(b) of such Act by adding a new paragraph (6). New paragraph (6) provides that payment for a second or third opinion

under a Medicare demonstration project shall be on an assignment basis.

Section 37(b)(4) provides that the amendments made by Section 37 shall take effect with respect to opinions provided on or after the first day of the first month beginning after the date of the enactment of the bill.

Section 37(c)(1) amends Section 1903(a) of the Social Security Act by adding a new paragraph (7). New paragraph (7) provides for 90 percent Federal matching for the performance of a second or third opinion as to necessity and appropriateness of specified elective surgical procedures under a Medicaid demonstration project.

Section 37(c)(2) makes a conforming change in the Social Security Act.

Section 37(c)(3) provides that the amendments made by section 37(c) shall apply to calendar quarters beginning on or after October 1, 1980.

Section 38. Application of informed consent to certain demonstration projects

Section 38 provides that a demonstration project under new Section 1130 of the Social Security Act (as added by Section 37 of the bill) shall not apply to an individual unless the individual has provided a written and legally effective informed consent, described in section 46.103(c) of title 45, Code of Federal Regulations, to participate in the project. This section shall apply notwithstanding section 37(a)(2) of this bill (providing that second opinion demonstration projects shall not be construed to be subject to any of the requirements of 45 C.F.R. Part 46) and new Section 1130(d)(1) of the Social Security Act, as added by Section 37 (prohibiting except under certain circumstances, payment for specified elective procedures covered under a second opinion demonstration project if a second opinion has not been obtained).

Section 39. Continued use of demonstration project reimbursement systems

Section 24A amends Section 1814(b) of the Social Security Act by adding a new paragraph (3). The new paragraph (3) provides for the continued use, in hospitals which have been reimbursed under such systems, of reimbursement systems, approved for use as a demonstration project under Section 402 of the Social Security Amendments of 1967, provided the following conditions are met:

(A) Some or all of the hospitals in the State have been reimbursed for Medicare services pursuant to such reimbursement systems.

(B) The rate of increase in such hospitals' costs per inpatient admission for Medicare beneficiaries was equal to or less than such increase with respect to all U.S. hospitals during the duration of the project.

(C) Either the State has legislative authority to operate such a system and it elects to continue the reimbursement system for such hospitals; or the system is operated through a voluntary agreement of hospitals and they elect to have such reimbursement to such hospitals continued.

The hospitals shall continue to be reimbursed under the demonstration project reimbursement system until the Secretary determines that:

(A) A third party payor reimburses such a hospital on another basis; or

(B) The rate of increase for the previous three year period in costs per inpatient admission for Medicare beneficiaries in such hospitals is greater than such rate of increase in all U.S. hospitals over such period.

Section 24A(b) amends Section 1902(a)(13)(D) of the Social Security Act to provide that hospitals which are reimbursed for Medicare Part A services in accordance with the new Section 1814(b)(3) must be reimbursed for inpatient services according to the same system under Medicaid.

VI. Changes in Existing Law Made by the Bill, As Reported

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

Social Security Act

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TITLE V—MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES

* * * * * * *

APPROVAL OF STATE PLANS

Sec. 505. (a) In order to be entitled to payments from allotments under section 502, a State must have a State plan for maternal and child health services and services for crippled children which—

(1) * * *

* * * * * * *

(14) provides that acceptance of family planning services provided under the plan shall be voluntary on the part of the individual to whom such services are offered and shall not be a prerequisite to eligibility for or the recipt of any service under the plan; [and]

(15) provides—

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of services under the plan and, where applicable, for providing guidance with respect thereto to the other State agency referred to in paragraph (2); and

(B) that the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1864(a), or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform the function of determining whether institutions and agencies meet the requirements for participation in the program under the plan under this title[.] *; and*

(16) provides (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that such audits, for entities also providing services under title XVIII, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such part, and (C) for payment of such proportion of costs of each such common audit as is determined under methods specified by the Secretary under section 1128(a).

TITLE XI—GENERAL PROVISIONS AND PROFESSIONAL STANDARDS REVIEW

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Part A—General Provisions

DEFINITIONS

Sec. 1101. (a) When used in this Act—

(1) The term "State", except where otherwise provided, includes the District of Columbia and the Commonwealth of Puerto Rico, and when used in titles IV, V, VII, XI, and XIX includes the Virgin Islands and Guam. Such term when used in [title V] *titles V and XIX* and in part B of this title also includes [American Samoa] *the Northern Mariana Islands, American Samoa*, and the Trust Territory of the Pacific Islands. Such term when used in titles III, IX, and XII also includes the Virgin Islands. In the case of Puerto Rico, the Virgin Islands, and Guam, title I, X, and XIV, and title XVI, (as in effect without regard to the amendment made by section 301 of the Social Security Amendments of 1972) shall continue to apply, and the term "States" when used in such titles (but not in title XVI as in effect pursuant to such amendment after December 31, 1973) includes Puerto Rico, the Virgin Islands, and Guam.

LIMITATION ON PAYMENTS TO PUERTO RICO, THE VIRGIN ISLANDS, AND GUAM

Sec. 1108. (a) * * *

* * * * * * *

[(c) The total amount certified by the Secretary under title XIX with respect to any fiscal year—

[(1) for payment to Puerto Rico shall not exceed $30,000,000,

[(2) for payment to the Virgin Islands shall not exceed $1,000,000, and

[(3) for payment to Guam shall not exceed $900,000.]

(c) The total amount certified by the Secretary under title XIX with respect to—

(1) fiscal year 1980, for payment—

(A) to the Commonwealth of Puerto Rico shall not exceed $60,000,000,

(B) to the Virgin Islands shall not exceed $2,000,000,

(C) to Guam shall not exceed $1,800,000,

(D) to the Northern Mariana Islands shall not exceed $250,000,

(E) to America Samoa shall not exceed $500,000, and

(F) to the Trust Territory of the Pacific Islands shall not exceed $1,800,000, and

(2) any subsequent fiscal year, for payment to the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, American Samoa, and the Trust Territory of the Pacific Islands shall not exceed the amount specified in subparagraphs (A), (B), (C), (D), (E), and (F), respectively, of paragraph (1) increased by a percentage equal to the percentage increase in the Consumer Price Index for all urban consumers (published monthly by the Bureau of Labor Statistics of the Department of Labor) between October 1980, and the first month of such fiscal year.

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LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES

SEC. 1122. (a) * * *

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(j) A capital expenditure made by or on behalf of a health care facility shall not be subject to review pursuant to this section if the obligation of the capital expenditure by the facility would not be required to be reviewed under section 1527 of the Public Health Service Act.

PROGRAM FOR DETERMINING QUALIFICATIONS FOR CERTAIN HEALTH CARE PERSONNEL

SEC. 1123. (a) The Secretary, in carrying out his functions relating to the qualifications for health care personnel under title XVIII, shall develop (in consultation with appropriate professional health organizations and State health and licensure agencies) and conduct (in conjunction with State health and licensure agencies) until December 31, [1977,] *1980*, a program designed to determine the proficiency of individuals (who do not otherwise meet the formal educational, professional membership, or other specific criteria established for determining the qualifications of practical nurses, therapists, laboratory technicians, and technologists, and cytotechnologists, X-ray technicians, psychiatric technicians, or other health care technicians and technologists) to perform the duties and functions of practical nurses, therapists, laboratory technicians, technologists, and cytotechnologists, X-ray technicians, psychiatric technicians, or other health care technicians and technologists. Such program shall include (but not

be limited to) the employment of procedures for the formal testing of the proficiency of individuals. In the conduct of such program, no individual who otherwise meets the proficiency requirements for any health care specialty shall be denied a satisfactory proficiency rating solely because of his failure to meet formal educational or professional membership requirements.

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DISCLOSURE OF OWNERSHIP AND RELATED INFORMATION

SEC. 1124. (a)(1) The Secretary shall by regulation or by contract provision provide that each disclosing entity (as defined in paragraph (2)) shall—

(A) as a condition of the disclosing entity's participation in, or certification or recertification under, any of the programs established by titles V, XVIII, XIX, and XX, or

(B) as a condition for the approval or renewal of a contract or agreement between the disclosing entity and the Secretary or the appropriate State agency under any of the programs established under titles V, XVIII, XIX, and XX,

supply the Secretary or the appropriate State agency with full and complete information as to the identity of each person with an ownership or control interest (as defined in paragraph (3)) in the entity or in any subcontractor (as defined by the Secretary in regulations) in which the entity directly or indirectly has a 5 per centum or more ownership interest.

(2) As used in this section, the term "disclosing entity" means an entity which is—

(A) a provider of services (as defined in section 1861(u), other than a fund), an independent clinical laboratory, a renal disease facility, or a health maintenance organization [(as defined in section 1301(a) of the Public Health Service Act)];

(B) an entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, items or services with respect to which payment may be claimed by the entity under any plan or program established pursuant to title V or under a State plan approved under title XIX;

(C) a carrier or other agency or organization that is acting as a fiscal intermediary or agent with respect to one or more providers of services (for purposes of part A or part B of title XVIII, or both, or for purposes of a State plan approved under title XIX) pursuant to (i) an agreement under section 18816, (ii) a contract under section 1842, or (iii) an agreement with a single State agency administering or supervising the administration of a State plan approved under title XIX; or

(D) an entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health related services with respect to which payment may be claimed by the entity under a State plan or program approved under title XX.

(3) As used in this section, the term "person with an ownership or control interest" means, with respect to an entity, a person who—

(A) (i) has directly or indirectly (as determined by the Secretary in regulations) an ownership interest of 5 per centum or more in the entity; or

[(ii) is the owner (in whole or in part) of an interest of 5 per centum or more in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof; or]

(ii) is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof, which whole or part interest is equal to or exceeds $25,000 or 5 per centum of the total property and assets of the entity; or

(B) is an officer or director of the entity, if the entity is organized as a corporation; or

(C) is a partner in the entity, if the entity is organized as a partnership.

EXCLUSION OF CERTAIN INDIVIDUALS CONVICTED OF MEDICARE- OR MEDICAID-RELATED CRIMES

SEC. 1127. (a) Whenever the Secretary determines that a physician or other individual has been convicted (on or after October 25, 1977, or within such period prior to that date as the Secretary shall specify in regulations) of a criminal offense related to such individual's participation in the delivery of medical care or services under title XVIII or title XIX, the Secretary—

(1) shall bar from participation in the program under title XVIII, for such period as he may deem appropriate, each such individual otherwise eligible to participate in such program;

(2) (A) shall promptly notify each appropriate State agency administering or supervising the administration of a State plan approved under title XIX, of the fact and circumstances of such determination, and (except as provided in subparagraph (B)) require each such agency to bar such individual from participation in such program for such period as he shall specify, which in the case of an individual specified in paragraph (1) shall be the period established pursuant to paragraph (1);

(B) may waive the requirement under subparagraph (A) to bar an individual from participation in a State plan program under title XIX, where he receives and approves a request for such a waiver with respect to that individual from the State agency administering or supervising the administration of such plan; and

(3) shall promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of such individual of the fact and circumstances of such determination, request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and request that such State or local agency or authority keep the Secretary and the Inspector General of the Department of Health, Education, and Welfare fully and currently informed with respect to any actions taken in response to such request.

(b) A determination made by the Secretary under this section shall be effective at such time and upon such reasonable notice to the public

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and to the person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of inpatient hospital services, post-hospital extended care services, and home health services furnished under title XVIII, such determination shall be effective in the manner provided in paragraphs (3) and (4) of section 1866(b) with respect to terminations of agreements), and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

(c) Any person who is the subject of an adverse determination made by the Secretary under subsection (a) shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

COORDINATED AUDITS

SEC. 1128. (a) If an entity provides services reimbursable on a cost-related basis under title V or XIX, as well as services reimbursable on such a basis under title XVIII, the Secretary shall require, as a condition for payment to any State under title V or XIX with respect to administrative costs incurred in the performance of audits of the books, accounts, and records of that entity, that these audits be coordinated through common audit procedures with audits performed with respect to the entity for purposes of title XVIII. The Secretary shall specify by regulation such methods as he finds feasible and equitable for the apportionment of the cost of coordinated audits between the program established under title V or XIX and the program established under title XVIII. Where the Secretary finds that a State has declined to participate in such a common audit with respect to title V or XIX, he shall reduce the payments otherwise due such State under such title by an amount which he estimates to be in excess of the amount that would have been apportioned to the State under the title (for the expenses of the State incurred in the common audit) if it had participated in the common audit.

(b)(1) In the case of entities which have audits coordinated under subsection (a), the Secretary shall establish one or more projects to demonstrate the feasibility of creating a single coordinated appeal hearing to adjudicate those administrative cost items which are determined under such a coordinated audit and which such entities dispute and appeal.

(2) In the case of a demonstration project under this subsection, the Secretary may waive such requirements of title V, XVIII, or XIX as would prevent carrying out the project or would require duplicative activity or otherwise create unnecessary administrative burdens in carrying out the project.

(3) The Secretary shall report to Congress not later than April 1, 1982, on demonstration projects conducted under this subsection, including the reaction of the entities involved and estimates of any savings effected through reduction of duplication of appeal hearings, and shall include in such report recommendations for such legislation as

the Secretary deems appropriate to insure the maximum feasible coordination of such appeal hearings.

(4) The Secretary shall also provide for the review of the feasibility of establishing a single coordinated process for the collection of overpayments established in a coordinated audit under subsection (a). The Secretary shall report to Congress not later than April 1, 1981, on such review and on such recommendations for changes in legislation as the Secretary deems appropriate.

QUALITY ASSURANCE PROGRAMS FOR CLINICAL LABORATORIES

SEC. 1129. In exercising the authority provided under sections 1861(e) and 1861(s) of this Act for assuring the quality of diagnostic tests performed in hospital and independent laboratories, the Secretary shall—

(1) only impose such requirements, in addition to those provided for by State or local law, as are found by the Secretary to be necessary to correct deficiencies in the quality of particular types of tests or laboratories;

(2) employ quility assurance methods designed to result in—

(A) the least imposition of costs, and

(B) the fewest restrictions on the personnel who may perform or supervise such tests,

consistent with adequate standards of quality assurance; and

(3) to the extent feasible, employ quality assurance methods which take into account and are appropriate to the different types of laboratories to which they apply.

DEMONSTRATION PROJECTS FOR REQUIRING SECOND OPINIONS FOR CERTAIN ELECTIVE SURGICAL PROCEDURES UNDER MEDICARE AND MEDICAID

SEC. 1130. (a)(1) The Secretary is authorized to make grants to, and enter into contracts with, public and private non-profit entities, including professional standards review organizations designated (conditionally or otherwise) under part B of this title and medical societies, for the conduct of demonstration projects for the purpose of determining the cost-effectiveness and appropriateness of requiring that a second opinion with respect to specified elective surgical procedures (defined in subsection (f)(1)) be provided before payment may be made under title XVIII or under a State plan approved under title XIX with respect to the performance of the procedure.

(2) To the extent feasible, the Secretary shall provide under this section for—

(A) demonstration projects applicable to all specified elective surgical procedures proposed to be furnished to individuals entitled to hospital insurance benefits under part A, and enrolled under the supplementary medical insurance program under part B, of title XVIII of this Act, and

(B) demonstration projects applicable to all specified elective surgical procedures proposed to be furnished to individuals eligible for medical assistance under State plans approved under title XIX of this Act.

(3) The Secretary shall provide, to the extent feasible—

(A) for at least seven demonstration projects under this section,

(B) that the number of such projects conducted be equally divided between projects described in paragraph (2)(A) and projects described in paragraph (2)(B), and

(C) for the conduct of such projects in a variety of geographic settings and covering a variety of sizes of populations, in order to determine the relative effectiveness of requiring second opinions in different areas of the country and under programs of different sizes.

(b)(1) No grant may be made or contract entereed into under this section unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary may provide.

(2) The amount of any grant or contract under this section shall be determined by the Secretary.

(3) Grants and payments under contracts made for demonstration projects and related administrative expenses (including expenses for analysis of data) described—

(A) in subsection (a)(2)(A) shall be made in appropriate part from the Federal Hospital Insurance Trust Fund (established by section 1817) and the Federal Supplementary Medical Insurance Trust Fund (established by section 1841), and

(B) in subsection (a)(2)(B) shall be made from funds appropriated under title XIX of this Act.

Grants and payments under contracts may be made either in advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this section.

(4) In addition to any other authority provided under part B of this title, professional standards review organizations designated (conditionally or otherwise) under such part are authorized to receive grants and enter into contracts for demonstration projects under this section.

(5) For administrative expenses (including analysis of data) associated with demonstration projects under this section, there is authorized to be appropriated for fiscal year 1981 an amount, not to exceed $7,000,000, to remain available until expended.

(c) No grant or contract shall be made with respect to a demonstration project under this section unless the project meets the following requirements:

(1) The project must potentially apply to a sufficiently large population of individuals eligible for benefits under part A of title XVIII (in the case of a project described in subsection (a)(2)(A)) or under the State plan (in the case of a project described in subsection (a)(2)(B)) for specified elective surgical procedures recommended during a two-year period, so as to provide for statistically valid data to properly evaluate the project.

(2)(A) The project must provide (through the entity or the Secretary) for notice to the applicable population, and, to the extent feasible, to physicians and hospitals which may provide

specified elective surgical procedures for such population, of the existence of the demonstration project and the requirement of subsection (d) for a second opinion as a condition of payment for such procedures, and must include in such notice made to the applicable population a general description of the procedure and techniques available for the treatment of the condition for treatment of which a specified elective surgical procedure has been recommended.

(B) The project must provide for making available to individuals covered under the project lists of qualified physicians who have indicated that they will provide, in accordance with the provisions of the project, written opinioins with respect to the necessity and appropriateness of particular specified elective surgical procedures.

(3) To the extent practicable and consistent with the protection of patient privacy, the project must be so designed as—

(A) to prevent the qualified physician providing the second or third opinion from knowing the identity of the physician who provided a previous opinioin with respect to that procedure, and

(B) to avoid duplication of laboratory and other tests required in order to render such an opinion.

(4) The project must provide that for the transmittal to the Secretary—

(A) of interim data on the project's performance not later than eighteen months after the date the project is initiated, and

(B) of final data on its performance not later than six months after the end of the two-year period described in paragraph (1).

(d)(1) Notwithstanding any other provision of law (except as provided in paragraph (2)), if a specified elective surgical procedure to be furnished to an individual is covered under a demonstration project under this section applicable to title XVIII or to a State plan approved under title XIX, no payment may be made under such title or plan, respectively, with respect to the procedure unless the individual has been furnished, before the procedure is undertaken, at least—

(A) one written opinion by a physician described in subsection (f)(2)(A), an

(B) one written opinion by a qualified physician (as defined in subsection (f)(2)),

based on all factors deemed relevant to the determination, respecting the necessity and appropriateness of the procedure.

(2) Paragraph (1) shall not apply—

(A)(i) in the case of a demonstration project described in subsection (a)(2)(A), to procedures furnished by or through a health maintenance organization under a risk sharing contract entered into with the Secretary pursuant to section 1876(i)(2)(A), or

(ii) in the case of a demonstration project described in subsection (a)(2)(B), to procedures furnished by or through a health

maintenance organization which provides to the enrollees, on a prepaid capitation risk basis or on any other risk basis, such procedures; and

(B) in the case in which the patient is unable, because of severe physical or cognitive limitations, to understand the requirement of such paragraph or in such other cases as the Secretary determines that equity requires that such paragraph not apply.

(e) The Secretary shall analyze the data on demonstration projects transmitted to him under this section and shall submit to the Congress—

(1) not later than two years after the date of the enactment of this Act, an interim report on the demonstration projects assisted under this section, and

(2) not later than four years after the date of the enactment of this Act, a final report on the demonstration projects assisted under this section.

Such final report shall include such recommendations for changes in legislation with respect to imposing the requirement described in subsection (d) with respect to some or all of the specified elective surgical procedures as the Secretary determines to be appropriate.

(f) For purposes of this section:

(1) The term "specified elective surgical procedure" means—

(A) in the case of a demonstration project applicable to the medicare program—

(i) cholycystectomy,
(ii) menisectomy,
(iii) prostatectomy,
(iv) cataract surgery,
(v) hemorrhoidectomy, and
(vi) excision of varicose veins; and

(B) in the case of a demonstration project applicable to State plans approved under title XIX of this Act—

(i) hysterectomy,
(ii) menisectomy,
(iii) submucous resection,
(iv) hemorrhoidectomy,
(v) excision of varicose veins, and
(vi) tonsillectomy and adenoidectomy,

if such procedures are medically necessary to treat other than an emergency medical condition. In addition, such term includes such other elective surgical procedures as the Secretary, in his discretion, determines to be appropriate.

(2) The term "qualified physician" means, with respect to an opinion on a specified elective surgical procedure for treatment of a medical condition of a particular patient, a physician who—

(A) is a board-eligible or certified specialist with respect to the procedure or with respect to treatment of the medical condition or who possesses such other qualifications with respect to such procedure or treatment as the Secretary may specify;

(B) agrees not to perform the surgical procedure for which the opinion is sought (except under emergency conditions); and

(C) is not affiliated with a physician who provided a previous opinion with respect to such treatment of such patient.

ENCOURAGEMENT OF NONPROFIT HOSPITAL PHILANTHROPY

SEC. 1132. (a) It is the policy of the United States that philanthropic support for health care be encouraged and expanded, especially in support of experimental and innovative efforts to improve the health care delivery system.

(b) For purposes of determining under titles, V, XVIII, and XIX the reasonable costs of services furnished by nonprofit hospitals, unrestricted grants, gifts, and income from endowments shall not be deducted from any operating costs of such hospitals, and, in addition, the following items shall not be deducted from any operating costs of such hospitals:

(1) A donor designated or restricted grant, gift, or income from an endowment, as defined in section 405.423(b)(2) of title 42 of the Code of Federal Regulations.

(2) An unrestricted grant or gift, or income from such a grant or gift, which is not available for use as operating funds because of its designation by the hospital's governing board.

(3) A grant or similar payment which is made by a governmental entity and which is not available, under the terms of the grant or payment, for use as operating funds.

(4) The sale or mortgage of any real estate or other capital assets of the hospital which the hospital acquired through a gift or grant and which is not available for use as operating funds under the terms of the gift or grant or because of its designation by the hospital's governing board, except for recovery of the appropriate share of gains and losses realized from the disposal of depreciable assets.

(5) A sinking fund which is (A) created by the hospital in order to meet a condition imposed by a third party for the third party's financing of a capital improvement of the hospital, and which fund is used exclusively to make payments to such third party for the financing of the capital improvement.

PART B—PROFESSIONAL STANDARDS REVIEW

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DESIGNATION OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 1152. (a) * * *

(b) For purposes of subsection (a), the term "qualified organizations" means—

(1) when used in connection with any area—

(A) an organization (i) which is a nonprofit professional association (or a component organization thereof), (ii) which is composed of licensed doctors of medicine or osteopathy engaged in the practice of medicine or surgery in such area, *and, if the organization so elects, of other health care practitioners engaged in the practice of their professions in such area who hold independent hospital admitting privileges,*

(iii) the membership of which includes a substantial proportion of all such physicians in such area, (iv) which is organized in a manner which makes available professional competence to review health care services of the types and kinds with respect to which Professional Standards Review Organizations have review responsibilities under this part, (v) the membership of which is volunutary and open to all doctors of medicine or osteopathy licensed to engage in the practice of medicine or surgery in such area without requirement of membership in or payment of dues to any organized medical society or association, and (vi) which does not (*except as otherwise provided under section 1155(c)*) restrict the eligibility of any member for service as an officer of the professional Standards Review Organization or eligibility for and assignment to duties of such Professional Standards Review Organization, or, subject to subsection (c)(1),

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TRIAL PERIOD FOR PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 1154. (a) * * *

(b) During any such trial period (which may not exceed 48 months except as provided in subsection (c), the Secretary may require a Professional Standards Review Organization to perform, in addition to review of health care services [provided by or in institutions, only such of the duties and functions required under this part of Professional Standards Review Organization as he determines such organizations to be capable of performing] (*other than ancillary, ambulatory care, and long-term care services*) *provided by or in hospitals, only such of the duties and functions as he requires the organization to perform under subsection (f)(2) or subsection (f)(4) and which the organization is capable of performing.* The number and type of such duties shall, during the trial period, be progressively increased as the organization becomes capable of added responsibility so that, by the end of such period, such organization shall be considered a qualified organization only if the Secretary finds that it is substantially carrying out in a satisfactory manner, the activities and functions required of [Professional Standards Review Organizations under this part with respect to the review of health care services provided by or in institutions (including ancillary services) and, in addition, review of such other health care services as the Secretary may require] *that Professional Standards Review Organization under this part.* Any of such duties and functions not performed by such organization during such period shall be performed in the manner and to the extent otherwise provided for under law.

"(c) If the Secretary finds that an organization designated under subsection (a) has been unable to perform satisfactorily all of the duties and functions required under this part *of that organization* for reasons beyond the organization's control, he may extend such organization's trial period for an additional period not exceeding twenty-four months.

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(f)(1) The Secretary shall establish a program (hereinafter in this subsection referred to as the 'program') for the evaluation of the cost-effectiveness of review of particular health care services by Professional Standards Review Organizations.

(2) In order to demonstrate the cost-effectiveness of requiring review of particular health care services before such review is generally required, the program shall be designed in a manner so that the Secretary will require particular Professional Standards Review Organizations, chosen by a statistically valid method that will permit a valid evaluation of the cost-effectiveness of such review, to review particular health care services.

(3) The program shall provide for the evaluation of cost-effectiveness of the review of particular health care services under the program, particularly in comparison with areas in which such review was not required or performed.

(4) Based upon such evaluation, or upon an evaluation of comparable statistical validity, and a finding that review of particular health care services is cost-effective or yields other significant benefits, the Secretary shall specify such particular health care services which Professional Standards Review Organiaztions (either generally or under such conditions and circumstances as the Secretary may specify) have the duty and function of reviewing under this part.

(5) For purposes of this subsection, the term 'particular health care services' does not include health care services (other than ancillary, ambulatory care, and long-term care services) provided by or in hospitals.

DUTIES AND FUNCTIONS OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

SEC. 1155. (a)(1) Notwithstanding any other provision of law, but consistent with the provisions of this part, it shall be the duty and function of each Professional Standards Review Organization for any area to assume, [at the earliest date practicable] *to the extent and at the time specified by the Secretary under section 1154(f);* responsibility for the review of the professional activities in such area of physicians and other health care practitioners and institutional and noninstitutional providers of health care services in the provision of health care services (except as provided in paragraph (7)) and items for which payment may be made (in whole or in part) under this Act for the purpose of determining whether—

(A) such services and items are or were medically necessary;

(B) the quality of such services meets professionally recognized standards of health care; and

(C) in case such services and items are proposed to be provided in a hospital or other health care facility on an inpatient basis, such services and items could, consistent with the provision of appropriate medical care, be effectively provided on an outpatient basis or more economically in an inpatient health care facility of a different type.

[(2) Each Professional Standards Review Organization shall have the authority to determine, in advance, in the case of—

[(A) any elective admission to a hospital, or other health care facility, or

[(B) any other health care service which will consist of extended or costly courses of treatment,

whether such service, if provided, or if provided by a particular health care practitioner or by a particular hospital or other health care facility, organization, or agency, would meet the criteria specified in clauses (A) and (C) of paragraph (1).]

(2) Each Professional Standards Review Organization shall have the authority to determine, in advance, in the case of—

(A) any elective admission to a hospital or other health care facility (including admissions occurring on weekends),

(B) any routine diagnostic services furnished in connection with such an admission, and

(C) any other health care service which will consist of extended or costly courses of treatment,

whether such service, if provided, or if provided by a particular health care practitioner or by a particular hospital or other health care facility, organization, or agency, would meet the criteria specified in subparagraphs (A) and (C) of paragraph (1).

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(7)(A) Except as provided in subparagraph (B), a Professional Standards Review Organization located in a State has the function and duty to assume responsibility for the review under paragraph (1) of professional activities in intermediate care facilites (as defined in section 1905(c)) and in public institutions for the mentally retarded (described in section 1905(a)(1) only, *consistent with section 1154(f)*, if (i) the Secretary finds, on the basis of such documentation as he may require from the State, that the single State agency which administers or supervises the administration of the State plan approved under title XIX for that State is not performing effective review of the quality and necessity of health care services provided in such facilities and institutions, or (ii) the State requests such organization to assume such responsibility.

(B) A Professional Standards Review Organization located in a State has the function and duty to assume responsibilty for the review under paragraph (1) of professional activities in intermediate care facilities in the State that are also skilled nursing facilities (as defined in section 1861(j)), to the extent (*consistent with section 1154 (f)*) that the Secretary finds that the performance of such function by the single State agency (described in subparagraph (A)) for that State is inefficient.

(8) Each Professional Standards Review Organization shall consult (with such frequency and in such manner as may be prescribed by the Secretary) with representatives of health care practitioners (other than physicians described in section 1861(r)(1)) and of institutional and noninstitutional providers of health care services, in relation to the Professional Standards Review Organization's responsibility for the review under paragraph (1) of the professional activities of such practitioners and providers.

(e)(1) Each Professional Standards Review Organization shall utilize the services of, and accept the findings of, the review committees of a hospital (including any skilled nursing facility, as defined in section 1861(j), or intermediate care facility, as defined in section 1905(c), which is also a part of such hospital) or other operating health care facility or organization (other than such a skilled nursing facility or intermediate care facility which is not a part of a hospital) located in the area served by such organization, but only when and only to the extent and only for such time that such committees in such hospital or other operating health care facility or organization have demonstrated to the satisfaction of such organization their capacity [effectively and in timely fashion] *effectively, efficiently, and in timely fashion* to review activities in such hospital or other operating health care facility or organization (including the medical necessity of admissions, types and extent of services ordered, and lengths of stay) so as to aid in accomplishing the purposes and responsibilities described in subsection (a)(1), except where the Secretary disapproves, for good cause, such acceptance.

(2) The Secretary may prescribe regulations to carry out the provisions of this subsection.

[(g)(1) Where a Professional Standards Review Organization (whether designated on a conditional basis or otherwise) requests review responsibility with respect to services furnished in shared health facilities, the Secretary must give priority to such request, with the highest priority being assigned to requests from organizations located in areas with substantial numbers of shared health facilities.

[(2) The Secretary shall require any Professional Standards Review Organization which is capable of exercising review responsibility with respect to ambulatory care services to perform review responsibility with respect to such services on and after a date not earlier than the date the organization is designated as a Professional Standards Review Organization (other than under section 1154) and not later than two years after the date the organization has been so designated, but any such designated Professional Standards Review Organization may be approved to perform such review responsibility at any earlier time if such organization applies for, and is found capable of exercising, such responsibility.]

(h) If the Secretary has designated an organization (other than under section 1154) as a Professional Standards Review Organization, but that organization has not assumed responsibility for the review of particular activities in its area included in subsection (a)(1), the Secretary may designate another qualified Professional Standards Review Organization (in reasonable proximity to the providers and practitioners whose services are to be reviewed) to assume the responsibility for the review of some or all of those particular activities.

STATEWIDE PROFESSIONAL STANDARDS REVIEW COUNCILS; ADVISORY GROUPS TO SUCH COUNCILS

SEC. 1162. (a) * * *

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(e)(1) The Statewide Professional Standards Review Council for any State [(or in a State which does not have such Council, the Pro-

fessional Standards Review Organizations in such State which have agreements with the Secretary)] shall be advised and assisted in carrying out its functions by an advisory group (of not less than seven nor more than eleven members) which shall be made up of representatives (*including at least one registered professional nurse and at least one doctor of dental surgery or of dental medicine*) of health care practitioners (other than physicians) and hospitals and other health care facilities which provide within the State health care services for which payment (in whole or in part) may be made under any program established by or pursuant to this Act.

(2) The Secretary shall by regulations provide the manner in which members of such advisory group shall be selected by the Statewide Professional Standards Review Council [(or Professional Standards Review Organizations in States without such Councils)].

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NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL

SEC. 1163. (a) (1) There shall be established a National Professional Standards Review Council (hereinafter in this section referred to as the "Council") which shall consist of eleven physicians, *one doctor of dental surgery or of dental medicine, one registered professional nurse, and one other health practitioner* (*other than a physician as defined in section 1861(r)(1)*), not otherwise in the employ of the United States, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service.

(2) Members of the Council shall be appointed for a term of three years, except that the Secretary may provide, in the case of any terms scheduled to expire after January 1, 1978, for such shorter terms as will ensure that (on a continuing basis) the terms of no more than [four] *five* members expire in any year. Members of the Council shall be eligible for reappointment.

(3) The Secretary shall from time to time designate one of the *physician* members of the Council to serve as Chairman thereof.

(b) [Members] *Physician members* of the Council shall consist of physicians of recognized standing and distinction in the appraisal of medical practice. A majority of such members shall be physicians who have been recommended by the Secretary to serve on the Council by national organizations recognized by the Secretary as representing practicing physicians. The membership of the Council shall include physicians who have been recommended for membership on the Council by consumer groups and other health care interests.

* * * * * * *

MEDICAL OFFICERS IN AMERICAN SAMOA, THE NORTHERN MARIANA ISLANDS, AND THE TRUST TERRITORY OF THE PACIFIC ISLANDS TO BE INCLUDED IN THE PROFESSIONAL STANDARDS REVIEW PROGRAM

SEC. 1173. For purposes of applying this part [(except sections 1155(c) and 1163)] (*except section 1155(c)*) to American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific

Islands, individuals licensed to practice medicine in those places shall be considered to be physicians and doctors of medicine.

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

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PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

DESCRIPTION OF PROGRAM

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CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

REQUIREMENT OF REQUESTS AND CERTIFICATIONS

SEC. 1814. (a) * * *

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AMOUNT PAID TO PROVIDERS

(b)(1) The amount paid to any provider of services with respect to services for which payment may be made under this part shall, subject to the provisions of section 1813, be—

(1) *except as provided in paragraph (3)*, the lesser of (A) the reasonable cost of such services, as determined under section 1861 (v) and as further limited by section 1881(b)(2)(B), or (B) the customary charges with respect to such services; or

(2) if such services are furnished by a public provider of services free of charge or at nominal charges to the public, the amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such reasonable cost which the Secretary finds will provide fair compensation to such provider for such services[.] *; or*

(3) if some or all of the hospitals in a State have been reimbursed for services (for which payment may be made under this part) pursuant to a reimbursement system approved as a demonstration project under section 402 of the Social Security Amendments of 1967 or section 222(a) of the Social Security Amendments of 1972, if the rate of increase in such hospitals in their costs per hospital inpatient admission of individuals entitled to benefits under this part over the duration of such project was equal to or less than such rate of increase for admissions of such individuals with respect to all hospitals in the United States during such period, and if either the State has legislative authority to operate such system and the State elects to have reimbursement to such hospitals made in accordance with this paragraph or the system is operated through a voluntary agreement of hospitals and such hospitals elect to have reimbursement to those hospitals made in accordance with this paragraph, then such hospitals shall

continue to be reimbursed under such system until the Secretary determines that—

(A) a third-party payor reimburses such a hospital on a basis other than under such system, or

(B) the rate of increase for the previous three-year period in such hospitals in costs per hospital inpatient admission of individuals entitled to benefits under this part is greater than such rate of increase for admissions of such individuals with respect to all hospitals in the United States for such period.

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PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

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SCOPE OF BENEFITS

SEC. 1832. (a) The benefits to an individual by the insurance program established by this part shall consist of—

(1) * * *

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

(A) home health services for up to 100 visits during a calendar year;

(B) medical and other health services furnished by a provider of services or by others under arrangement with them made by a provider of services, excluding—

(i) physician services except where furnished by—

(I) a resident or intern of a hospital, or

(II) a physician to a patient in a hospital which has a teaching program approved as specified in paragraph (6) of section 1861(b) (including services in conjunction with the teaching programs of such hospital whether or not such patient is an inpatient of such hospital) [, unless either clause (A) or (B) of paragraph (7) of such section is met] *where the conditions specified in paragraph (7) of such section are met*, and

(ii) services for which payment may be made pursuant to section 1835(b)(2); and

(C) outpatient physical therapy services, other than services to which the next to last sentence of section 1861(p) applies; and

* * * * * * *

PAYMENT OF BENEFITS

SEC. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program estab-

lished by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1832(a)(1)—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), (B) with respect to expenses incurred for radiological or pathological services for which payment may be made under this part, furnished to an inpatient of a hospital by a physician in the field of radiology or pathology, the amounts paid shall be equal to 100 percent of the reasonable charges for such services, (C) with respect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, (D) with respect to diagnostic tests performed in a laboratory for which payment is made under this part to the laboratory, the amounts paid shall be equal to 100 percent of the negotiated rate for such tests (as determined pursuant to subsection (g) of this section), [and] (E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1881, and (*F*) *with respect to a second or third opinion as to necessity and appropriateness of specified elective surgical procedures described in section 1130(f)(1)(A), the amounts paid shall be equal to 100 percent of the reasonable charge for such opinion, and*

* * * * * * *

(b) before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $60; except that (1) the amount of the deductible for such calendar year as so determined shall first be reduced by the amount of any expenses incurred by such individual in the last three months of the preceding calendar year and applied toward such individual's deductible under this section for such preceding year, [and] (2) such total amount shall not include expenses incurred for radiological or pathological services furnished to such individual as an inpatient of a hospital by a physician in the field of radiology or pathology, *and* (*3*) *such total amount shall not include expenses incurred for a second or third opinion described in subsection (a)(1)(F) for an elective surgical procedure.* The total amount of the expenses incurred by an individual as determined under the

preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence.

* * * * * * *

USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC. 1842. (a) * * *

(b)(1) Contracts with carriers under subsection (a) may be entered into without regard to section 3709 of the Revised Statutes or any other provision of law requiring competitive bidding.

(2) No such contract shall be entered into with any carrier unless the Secretary finds that such carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent.

(3) Each such contract shall provide that the carrier—

(A) will take such action as may be necessary to assure that, where payment under this part for a service is on a cost basis, the cost is reasonable cost (as determined under section 1861(v));

(B) will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier, and such payment will (except as otherwise provided *in paragraph (6) of this subsection or* in section 1870(f)) be made—

(i) * * *

* * * * * * *

(5) No payment under this part for a service provided to any individual shall (except as provided in section 1870) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or other person who provided the service, except that payment may be made (A) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or (B) (where the service was provided in a hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such

facility submits the bill for such service. No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of attorney (except to an employer or facility as described in clause (A) or (B) of such sentence); but nothing in this subsection shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the individual to whom the service was provided or a reassignment from the physician or other person providing such service if such assignment or reassignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of the physician or other person providing the service from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such physician or other person under this title is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment.

(6) No such contract shall provide for payment for a second or third opinion described in section 1833(a)(1)(F) on a basis other than that described in clause (ii) of paragraph (3)(B).

* * * * * * *

(h) If a physician's bill or request for payment for a physician's services includes a charge to a patient for a laboratory test for which payment may be made under this part, the amount payable with respect to the test shall be determined as follows:

(1) If the bill or request for payment indicates that the physician who submitted the bill or for whose services the request for payment was made personally performed or supervised the performance of the test or that another physician with whom the physician shares his practice personally performed or supervised the test, the payment shall be the reasonable charge for the test (less the applicable deductible and coinsurance amounts).

(2) If the bill or request for payment indicates that the test was performed by a laboratory, identifies the laboratory, and indicates the amount the laboratory charged the physician who submitted the bill or for whose services the request for payment was made, payment for the test shall be the lower of—

(A) the laboratory's reasonable charge to individuals enrolled under this part for the test, or

(B) the amount the laboratory charged the physician for the test,

plus a nominal fee (where the physician bills for such a service) to cover the physician's costs in collecting and handling the sample on which the test was performed (less the applicable deductible and coinsurance amounts).

(3) If the bill or request for payment (A) does not indicate who performed the test, or (B) indicates that the test was performed by a laboratory but does not identify the laboratory or in-

clude the amount charged by the laboratory, payment shall be the lowest charged at which the carrier estimates the test could have been secured by a physician from a laboratory serving the locality (less the applicable deductible and coinsurance amounts).

. . . . . .

PART C—MISCELLANEOUS PROVISIONS

DEFINITION OF SERVICE, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

Spell of Illness

(a) * * *

Inpatient Hospital Services

(b) The term "inpatient hospital services" means the following items and services furnished to an inpatient of a hospital and (except as provided in paragraph (3)) by the hospital—

(1) * * *

* * * * * * *

[(7) a physician where the hospital has a teaching program approved as specified in paragraph (6), unless (A) such inpatient is a private patient (as defined in regulations), or (B) the hospital establishes that during the two-year period ending December 31, 1967, and each year thereafter all inpatients have been regularly billed by the hospital for services rendered by physicians and reasonable efforts have been made to collect in full from all patients and payment of reasonable charges (including applicable deductibles and coinsurance) has been regularly collected in full or in substantial part from at least 50 percent of all inpatients.]

(7) a physician where the hospital has a teaching program approved as specific in paragraph (6), if (A) the hospital elects to receive any payment due under this title for reasonable costs of such services, and (B) all physicians in such hospital agree not to bill charges for professional services rendered in such hospital to individuals covered under the insurance program established by this title.

Skilled Nursing Facility

(j) The term "skilled nursing facility" means (except for purposes of subsection (a)(2)) an institution (or a distinct part of an institution) which has in effect a transfer agreement (meeting the requirements of subsection (1)) with one or more hospitals having agreements in effect under section 1866 and which—

(1) * * *

* * * * * * *

(13) meets such provisions of [the Life Safety Code of the National Fire Protection Association (23d edition, 1973) as are

applicable to nursing homes; except that the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a nursing home, but only if such waiver will not adversely affect the health and safety of the patients] *such edition (as specified by the Secretary in regulations) of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes*; except that the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects patients in nursing facilities;

* * * * * * *

Physicians' Services

(q) The term "physicians' services" means professional services performed by physicians, including surgery, consultation (*including consultation as to the necessity and appropriateness of elective surgical procedures*), and home, office, and institutional calls (but not including services described in subsection (b)(6)).

* * * * * * *

Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services:

(1) physicians' services;

(2)(A) * * *

* * * * * * *

(E) rural health clinic services; [and]

(F) home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies, *and*

(G) services furnished pursuant to a contract under section 1876 to a member of a health maintenance organization by a nurse practitioner and such services and supplies furnished as an incident to his service to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service;

* * * * * * *

(v)(1)(A) * * *

Reasonable Cost

* * * * * * *

(G) Where a hospital furnishes inpatient services that would otherwise constitute post-hospital extended care services if furnished by a skilled nursing facility on the basis of a determination made by a Professional Standards Review Organization (or, in the absence of such a qualified organization, by such organization or agency with review responsibility as is otherwise provided for under this title) that (i) post-hospital extended care services are medically necessary; and (ii) that such services are not otherwise available (as determined

in accordance with criteria established by the Secretary) at the time the determination is made that post-hospital extended care services rather than inpatient hospital services are medically necessary (and for such period as the circumstances described in clauses (i) and (ii) continue to apply); and where the Secretary finds that (I) such hospital has had, during the immediately preceding calendar year, an average daily occupancy rate of less than 80 percent, and (II) could be granted a certificate of need for the provision of long-term care services from the designated State health planning and development agency for the State in which the hospital is located, the reasonable cost of such services for such hospital shall be computed as provided for in section 1882(a). Where payment is made in accordance with the preceding sentence, the individual who is furnished such services will be deemed to have received post-hospital extended care services in like manner and to the same extent as if the services furnished to him had been post-hospital extended care services furnished by a skilled nursing facility under an agreement under section 1866.

* * * * * * *

RURAL HEALTH CLINIC SERVICES

(aa)(1) * * *

(2) The term "rural health clinic" means a facility which—

(A) is primarily engaged in furnishing to outpatients services described in subparagraphs (A) and (B) of paragraph (1);

(B) in the case of a facility which is not a physician-directed clinic, has an arrangement (consistent with the provisions of State and local law relative to the practice, performance, and delivery of health services) with one or more physicians (as defined in subsection (r)(1)) under which provision is made for the periodic review by such physicians of covered services furnished by physician assistants and nurse practitioners, the supervision and guidance by such physicians or physician assistants and nurse practitioners, the preparation by such physicians of such medical orders for care and treatment of clinic patients as may be necessary, and the availability of such physicians for such referral of and consultation for patients as is necessary and for advice and assistance in the management of medical emergencies; and, in the case of a physician-directed clinic, has one or more of its staff physicians perform the activities accomplished through such an arrangement;

(C) maintains clinical records on all patients;

(D) has arrangements with one or more hospitals, having agreements in effect under section 1866, for the referral and admission of patients requiring inpatient services or such diagnostic or other specialized services as are not available at the clinic;

(E) has written policies, which are developed with the advice of (and with provision for review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more physician assistants or nurse practitioners, to govern those services described in paragraph (1) which it furnishes;

(F) has a physician, physician assistant, or nurse practitioner responsible for the execution of policies described in subparagraph (E) and relating to the provision of the clinic's services,

(G) directly provides routine diagnostic services, including clinical laboratory services, as prescribed in regulations by the Secretary, and has prompt access to additional diagnostic services from facilities meeting requirements under this title;

(H) in compliance with State and Federal law, has available for administering to patients of the clinic at least such drugs and biologicals as are determined by the Secretary to be necessary for the treatment of emergency cases (as defined in regulations) and has appropriate procedures or arrangements for storing, administering, and dispensing any drugs and biologicals;

(I) has appropriate procedures for review of utilization of clinic services to the extent that the Secretary determines to be necessary and feasible; and

(J) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are furnished services by the clinic.

For the purposes of this title, such term includes only a facility which (i) is located in an area that is not an urbanized area (as defined by the Bureau of the Census) and that is designated by the Secretary either (I) as an area with a shortage of personal health services under section 1302(7) of the Public Health Service Act or (II) as a health manpower shortage area described in section 332(a)(1)(A) of that Act because of its shortage of primary medical care manpower, (ii) has filed an agreement with the Secretary by which it agrees not to charge any individual or other person for items or services for which such individual is entitled to have payment made under this title, except for the amount of any deductible or coinsurance amount imposed with respect to such items or services (not in excess of the amount customarily charged for such items and services by such clinic), pursuant to subsections (a) and (b) of section 1833, (iii) employs a physician assistance or nurse practitioner, and (iv) is not a rehabilitation agency or a facility which is primarily for the care and treatment of mental diseases. A facility that is in operation and qualifies as a rural health clinic under this title or title XIX and that subsequently fails to satisfy the requirement of clause (i) shall be considered, for purposes of this title and title XIX, as still satisfying the requirement of such clause.

Physician Assistant and Nurse Practitioner

[(3)] (*bb*) The term "physician assistant" and the term "nurse practitioner" mean[, for the purposes of paragraphs (1) and (2),] a physician assistant or nurse practitioner who performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law), and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.

* * * * * * *

EXCLUSIONS FROM COVERAGE

SEC. 1862. (a) * * *

* * * * * * *

[(e) (1) Whenever the Secretary determines that a physician or other individual practitioner has been convicted (on or after the date of the enactment of this subsection, or within such period prior to that date as the Secretary shall specify in regulations) of a criminal offense related to such physician's or practitioner's involvement in the programs under this title or the program under title XIX, the Secretary shall suspend such physician or practitioner from participation in the program under this title for such period as he may deem appropriate; and no payment may be made under this title with respect to any item or service furnished by such physician or practitioner during the period of such suspension. The provisions of paragraphs (2) and (3) of subsection (d) shall apply with respect to determinations made by the Secretary under this subsection.

[(2) In any case where the Secretary under paragraph (1) suspends any physician or other individual practitioner from participation in the program under this title, he shall—

[(A) promptly notify each single State agency which administers or supervises the administration of a State plan approved under title XIX of the fact, circumstances, and period of such suspension; and

[(B) promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of such physician or practitioner of the fact and circumstances of such suspension, request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and request that such State or local agency or authority keep the Secretary and the Inspector General of the Department of Health, Education, and Welfare fully and currently informed with respect to any actions taken in response to such request.]

(e) No payment may be made under this title with respect to any item or service furnished by a physician or other individual during the period when he is barred pursuant to section 1127 from participating in the program under this title.

* * * * * * *

USE OF STATE AGENCIES TO DETERMINE COMPLIANCE BY PROVIDERS OF SERVICES WITH CONDITIONS OF PARTICIPATION

SEC. 1864. (a) The Secretary shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by him for the purpose of determining whether an institution therein is a hospital or skilled nursing facility, or whether an agency therein is a home health agency, or whether a facility therein is a rural health clinic as defined in section 1861(aa)(2), or whether a laboratory meets the requirements of

paragraphs (10) and (11) of section 1861(s), or whether a clinic, rehabilitation agency or public health agency meets the requirements of subparagraph (A) or (B), as the case may be, of section 1861(p)(4). To the extent that the Secretary finds it appropriate, an institution or agency which such a State (or local) agency certifies is a hospital, skilled nursing facility, rural health clinic, or home health agency (as those terms are defined in section 1861) may be treated as such by the Secretary. [Any State agency which has such an agreement may (subject to approval of the Secretary) furnish to a skilled nursing facility after proper request by such facility, such specialized consultative services (which such agency is able and willing to furnish in a manner satisfactory to the Secretary) as such facility may need to meet one or more of the conditions specified in section 1861(j). Any such services furnished by a State agency shall be deemed to have been furnished pursuant to such agreement.] Within 90 days following the completion of each survey of any health care facility, rural health clinic, laboratory, clinic, agency, or organization by the appropriate State or local agency described in the first sentence of this subsection, the Secretary shall make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, rural health clinic, laboratory, clinic, agency, or organization with (1) the statutory conditions of participation imposed under this title and (2) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such health care facility, rural health clinic, laboratory, clinic, agency, or organization.

* * * * * * *

AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a) * * *

* * * * * * *

(f)(1) Where the Secretary determines that a skilled nursing facility which has filed an agreement pursuant to subsection (a)(1) or which has been certified for participation in a plan approved under title XIX no longer substantially meets the provisions of section 1861(j), and further determines that the facility's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the Secretary shall provide for the termination of the agreement or of the certification of the facility and shall provide, or

(B) do not immediately jeopardize the health and safety of its patients, the Secretary may, in lieu of terminating the agreement or certification of the facility, provide

that no payment shall be made under this title (and order a State agency established or designated pursuant to section 1902(a)(5) of this Act to administer or supervise the administration of the State plan under title XIX of this Act to deny payment under title XIX) with respect to any individual admitted to such facility after a date specified by him.

(2) The Secretary shall not make such a decision with respect to a facility until such facility has had a reasonable opportunity, follow-

ing the initial determination that it no longer substantially meets the provisions of section 1861(j), to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

(3) The Secretary's decision to deny payment may be made effective only after such notice to the public and to the facility as may be prescribed in regulations, and its effectiveness shall terminate (A) when the Secretary finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the provisions of section 1861(j), or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of section 1861(j) on the date specified in such clause, the Secretary shall terminate such facility's agreement or provide for termination of such facility's certification, notwithstanding the provisions of paragraph (2) of subsection (b), effective with the first day of the first month following the month specified in such clause.

* * * * * * *

[PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

[SEC. 1876. (a)(1) In lieu of amounts which would otherwise be payable pursuant to sections 1814(b) and 1833(a), the Secretary is authorized to determine, by actuarial methods, as provided in this section, but only with respect to a health maintenance organization with which he has entered into a contract under subsection (i), a per capita rate of payment—

[(A) for services provided under parts A and B for individuals enrolled with such organization pursuant to subsection (e) who are entitled to hospital insurance benefits under part A and enrolled for medical insurance benefits under part B, and

[(B) for services provided under part B for individuals enrolled with such organization pursuant to subsection (e) who are not entitled to benefits under part A but who are enrolled for benefits under Part B.

[(2) An interim per capita rate of payment for each health maintenance organization shall be determined annually by the Secretary on the basis of each organization's annual operating budget and enrollment forecast which shall be submitted (in such form and in such detail as the Secretary may prescribe) at least 90 days before the beginning of each contract year. Each interim rate shall be equal to the estimated per capita cost (based upon types and components of expenses otherwise reimbursable under this title) of providing services defined in paragraph (3)(A)(iii). In the event that the data requested to be furnished by a health maintenance organization are not furnished timely, such reduction in interim payments may be made by the Secretary as is appropriate, until such time as a reasonable estimate of per capita costs can be made. Each month, the Secretary shall pay each such organization its interim per capita rate, in advance, for each individual enrolled with it pursuant to subsection (e). Each such

organization shall submit interim estiamted cost reports and enrollment data on a quarterly basis in such form and manner satisfactory to the Secretary, and the Secretary shall adjust each interim per capita rate to the extent necessary to maintain interim payments at the level of current costs. Interim payments made under this paragraph shall be subject to retroactive adjustment at the end of each contract year as provided in paragraph (3).

[(3)(A) With respect to any health maintenance organization which has entered into a risk sharing contract with the Secretary pursuant to subsection (i)(2)(A) payments made to such organization shall be subject to the following adjustments at the end of each contract year:

[(i) if the Secretary determines that the per capita incurred cost of any such organization in any contract year for providing services described in paragraph (1) is less than the adjusted average per capita incurred cost (as defined herein) of providing such services, the resulting difference (hereinafter referred to as "savings") shall be apportioned following the close of a contract year for such year between such organization and the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (hereinafter collectively referred to as the "Medicare Trust Funds") as follows:

[(I) savings up to 20 percent of the adjusted average per capita cost shall be apportioned equally between such organization and the Medicare Trust Funds;

[(II) savings in excess of 20 percent of the adjusted average per capita cost shall be apportioned entirely to such Trust Funds;

[(ii) if the Secretary determines that the per capita incurred cost of any such organization in any contract year for providing services described in paragraph (1) is greater than the adjusted average per capita incurred cost of providing such services, the resulting difference (hereinafter referred to as "losses") shall be absorbed by such organization, and shall be carried forward and offset from savings realized in later years;

[(iii) determination of any amounts payable at the close of the contract year to such organization or to the Trust Funds shall be made as follows:

(I) within 90 days after close of a contract year, interim determination of the amount of estimated savings and apportionment thereof shall be made, actuarilly, on the basis of interim reports of costs incurred by an organization, and adjusted average per capita costs incurred (as defined herein), and other evidence acceptable to the Secretary and one-half of any amounts deemed payable to such organization or the Trust Funds shall be paid by such organization or the Secretary as appropriate;

[(II) final settlement and payment by the Secretary or organization, as appropriate, of any additional amounts due on basis of such final settlement will be made where adequate data for actuarial computation are available, in timely fashion following submission by such organization of reports specified in subparagraph (C) of this paragraph; and

[(III) where such final settlement is reached more then 90 days following submission of reports specified in subparagraph (C) of this paragraph, any amount payable by the Secretary or organization shall be increased by an interest amount, accruing from the 91st day following submission of such report, equal to the average rate of interest payable on Federal obligations if issued on such 91st day for purchase by the Trust Funds.

[(iv) The term "adjusted average per capita cost" means the average per capita amount that the Secretary determines (on the basis of actual experience, or retrospective actuarial equivalent based upon an adequate sample and other information and data, in the geographic area served by a health maintenance organization or in a similar area, with appropriate adjustment to assure actuarial equivalence, including adjustments relating to age distribution, sex, race, institutional status, disability status, and any other relevant factors) would be payable in any contract year for services covered under this title and types of expenses otherwise reimbursable under this title (including administrative costs incurred by organizations described in sections 1816 and 1842) if such services were to be furnished by other than such health maintenance organization.

[(B) With respect to any health maintenance organization which has entered into a reasonable cost reimbursement contract with the Secretary pursuant to subsection (i)(2)(B) payments made to such organization shall be subject to suitable retroactive corrective adjustments at the end of each contract year so as to assure that such organization is paid for the reasonable cost actually incurred (excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of health services) for the types of expenses otherwise reimbursable under this title for providing services covered under this title to individuals described in paragraph (1).

[(C) Any contract with a health maintenance organization under this title shall provide that the Secretary shall require, at such time following the expiration of each accounting period of a health maintenance organization (and in such form and in such detail) as he may prescribe:

[(i) that such health maintenance organization report to him in an independently certified financial statement its per capita incurred cost based on the types and components of expenses otherwise reimbursable under this title for providing services described in paragraph (1), including therein, in accordance with accounting procedures prescribed by the Secretary, its methods of allocating costs between individuals enrolled under this section and other individuals enrolled with such organizations;

[(ii) that failure to report such information as may be required may be deemed to constitute evidence of likely overpayment on the basis of which appropriate collection action may be taken;

[(iii) that in any case in which a health maintenance organization is related to another organization by common ownership or control, a consolidated financial statement shall be filed and that the allowable costs for such organization may not include costs

for the types of expense otherwise reimbursable under this title, in excess of those which would be determined to be reasonable in accordance with regulations (providing for limiting reimbursement to costs rather than charges to the health maintenance organization by related organizations and owners) isued by the Secretary in accordance with section 1861(v) of the Social Security Act; and

[(iv) that in any case in which compensation is paid by a health maintenance organization substantially in excess of what is normally paid for similar services by similar practitioners (regardless of method of compensation), such compensation may as appropriate be considered to constitute a distribution of profits.

[(4) The payments to health maintenance organizations under this subparagraph with respect to individuals described in subsection (a)(1)(A) shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The portion of such payment to such an organization for a month to be paid by the latter trust fund shall be equal to 200 percent of the sum of—

[(A) the product of (i) the number of covered enrollees of such organization for such month (as described in paragraph (1)), who have attained age 65, and (ii) the monthly actuarial rate for supplementary medical insurance for such month as determined under section 1938(c)(1), and

[(B) the product of (i) the number of covered enrollees of such organization for such month (as described in paragraph (1)) who have not attained age 65, and (ii) the monthly actuarial rate for supplementary medical insurance for such month as determined under section 1839(c)(4).

The remainder of such payment shall be paid by the former trust fund. For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122.

[(b)(1) The term "health maintenance organization" means a legal entity which provides health services on a prepayment basis to individuals enrolled with such organizations and which—

[(A) provides to its enrollees who are insured for benefits under parts A and B of this title or for benefits under part B alone, through institutions, entities, and persons meeting the applicable requirements of section 1861, all of the services and benefits covered under such parts (to the extent applicable under subparagraph (A) or (B) of subsection (a)(1)) which are available to individuals residing in the geographic area served by the organization;

[(B) provides such services in the manner prescribed by section 1301(b) of the Public Health Service Act, except that solely for the purposes of this section—

[(i) the term "basic health services" and references thereto shall be deemed to refer to the services and benefits included under parts A and B of this title;

[(ii) the organization shall not be required to fix the basic health services payment under a community rating system;

[(iii) the additional nominal payments authorized by section 1301(b)(1)(D) of such Act shall not exceed the limits applicable under subsection (g) of this section; and

[(iv) payment for basic health services provided by the organization to its enrollees under this section or for services such enrollees receive other than through the organization shall be made as provided for by this title;

[(C) is organized and operated in the manner prescribed by section 1301(c) of the Public Health Service Act, except that solely for the purposes of this section—

[(i) the term "basic health services" and references thereto shall be deemed to refer to the services and benefits included under parts A and B of this title;

[(ii) the organization shall not be reimbursed for the cost or reinsurance except as permitted by subsection (i) of this section; and

[(iii) the organization shall have an open enrollment period as provided for in subsection (k) of this section.

[(2)(A) The duties and functions of the Secretary, insofar as they involve making determinations as to whether an organization is a "health maintenance organization" within the meaning of paragraph (1), shall be administered through the Assistant Secretary for Health and in the Office of the Assistant Secretary for Health, and the administration of such duties and functions shall be integrated with the administration of section 1312 (a) and (b) of the Public Health Service Act.

[(B) Except as provided in subparagraph (A), the Secretary shall administer the provisions of this section through the Administrator of the Health Care Financing Administration.

[(c) The benefits provided under this section to enrollees of an organization which has entered into a risk sharing contract with the Secretary pursuant to subsection (i)(2)(A) shall consist of—

[(1) in the case of an individual who is entitled to hospital insurance benefits under part A and enrolled for medical insurance benefits under part B—

[(A) entitlement to have payment made on his behalf for all services described in section 1812 and section 1832 which are furnished to him by the health maintenance organization with which he is enrolled pursuant to subsection (e) of this section; and

[(B) entitlement to have payment made by such health maintenance organization to him or on his behalf for (i) such emergency services (as defined in regulations), (ii) such urgently needed services (as defined in regulations) furnished to him during a period of temporary absence (as defined in regulations) from the geographic area served by the health maintenance organization with which he is enrolled, and (iii) such other services as may be determined, in accordance with subsection (f), to be services which the individual was entitled to have furnished by the health maintenance organization, as may be furnished to him by a physician, supplier, or provider of services, other than the

health maintenance organization with which he is enrolled; and

[(2) in the case of an individual who is not entitled to hospital insurance benefits under part A but who is enrolled for medical insurance benefits under part B, entitlement to have payment made for services described in paragraph (1), but only to the extent that such services are also described in section 1832.

[(d) Subject to the provisions of subsection (e), every individual described in subsection (c) shall be eligible to enroll with any health maintenance organization (as defined in subsection (b)) which serves the geographic area in which such individual resides.

[(e) An individual may enroll with a health maintenance organization under this section, and may terminate such enrollment, as may be prescribed by regulations.

[(f) Any individual enrolled with a health maintenance organization under this section who is dissatisfied by reason of his failure to receive without additional cost to him any health service to which he believes he is entitled shall, if the amount in controversy is $100 or more, be entitled to a hearing before the Secretary to the same extent as is provided in section 205(b) and in any such hearing the Secretary shall make such healh maintenance organization a party thereto. If the amount in controversy is $1,000 or more, such individual or health maintenance organization shall be entitled to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

[(g)(1) If the health maintenance organization provides its enrollees under this section only the services described in subsection (c), its premium rate or other charges for such enrollees shall not exceed the actuarial value of the deductible and coinsurance which would otherwise be applicable to such enrollees under part A and part B, if they were not enrolled under this section.

[(2) If the health maintenance organization provides to its enrollees under this section services in addition to those described in subsection (c), election of coverage for such additional services shall be optional for such enrollees and such organization shall furnish such enrollees with information on the portion of its premium rate or other charges applicable to such additional services. The portion of its premium rate or other charges applicable to the services described in subsection (c) shall not exceed the actuarial value of the deductible and coinsurance which would otherwise be applicable to such enrollees under part A and part B if they were not enrolled under this section.

[(h)(1) Except as provided in paragraph (2), each health maintenance organization with which the Secretary enters into a contract under this section shall have an enrolled membership at least half of which consists of individuals who have not attained age 65.

[(2) The Secretary may waive the requirement imposed in paragraph (1) for a period of not more than three years from the date a health maintenance organization first enters into an agreement with the Secretary pursuant to subsection (i), but only for so long as such organization demonstrates to the satisfaction of the Secretary by the submission of its plan for each year that it is making continuous efforts

and progress toward compliance with the provisions of paragraph (1) within such three-year period.

[(i)(1) Subject to the limitations contained in subparagraph (A) and (B) of paragraph (2), the Secretary is authorized to enter into a contract with any health maintenance organization which undertakes to provide, on an interim per capita prepayment basis, the services described in section 1832 (and section 1812, in the case of individuals who are entitled to hospital insurance benefits under part A) to individuals enrolled with such organization pursuant to subsection (e).

[(2)(A) If the health maintenance organization (i) has a current enrollment of not less than 25,000 members on a prepaid capitation basis and has been the primary source of health care of at least 8,000 persons in each of the two years immediately preceding the contract year, or (ii) serves a nonurban geographic area, has a current enrollment of not less than 5,000 members on a prepaid capitation basis and has been the primary source of health care for at least 1,500 persons in each of the three years immediately preceding the contract year, the Secretary may enter into a risk sharing contract with such organization pursuant to which any savings, as determined pursuant to subsection (a)(3)(A), are shared between such organization and the Medicare Trust Funds in the manner prescribed in such subsection. For purposes of this subparagraph, a health maintenance organization shall be considered to serve a nonurban geographic area if it is located in a nonmetropolitan county (that is, a county with fewer than 50,000 inhabitants), or if it has at least one such county in its normal service area, or if it is located outside of a metropolitan area and its facilities are within reasonable travel distance (as defined by the Secretary) of fewer than 50,000 individuals. No health maintenance organization which has entered into a risk-sharing contract with the Secretary under this subparagraph and has voluntarily terminated such contract may again enter into such a contract.

[(B) If the health maintenance organization does not meet the requirements of subparagraph (A), or if the Secretary is not satisfied that the health maintenance organization has the capacity to bear the risk of potential losses as determined under clause (ii) of subsection (a)(3)(A), or if the health maintenance organization meeting the requirements of subparagraph (A) so elects, or if an organization does not fully meet the requirements of section 1876(b) but has demonstrated to the satisfaction of the Secretary that it is making reasonable efforts to meet, and is developing the capability to fully meet, such requirements, and that it fully meets such basic requirements as the Secretary shall prescribe in regulations, the Secretary may, if he is otherwise satisfied that the health maintenance organization or other organization is able to perform its contractual obligations effectively and efficiency, enter into a contract with such organization pursuant to which such organization is reimbursed on the basis of its reasonable cost (as defined in section 1861(v)) in the manner prescribed in subsection (a)(3)(B).

[(3) Such contract may, at the option ofsuch organization, provide that the Secretary (A) will reimburse hospitals and skilled nursing facilities for the reasonable cost (as determined under section

1861(v) of services furnished to individuals enrolled with such organization pursuant to subsection (e), and (B) will deduct the amount of such reimbursement from payments which would otherwise be made to such organization. If a health maintenance organization pays a hospital or skilled nursing facility directly, the amount paid shall not exceed the reasonable cost of the services (as determined under section 1861(v)) unless such organization demonstrates to the satisfaction of the Secretary that such excess payments are justified on the basis of advantages gained by the organization.

[(4) Each contract under this section shall be for a term of at least one year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the health maintenance organization involved as he may provide in regulations), if he finds that the organization (A) has failed substantially to carry out the contract, (B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this section, or (C) no longer substantially meets the applicable conditions of subsection (b).

[(5) The effective date of any contract executed pursuant to this subsection shall be specified in such contract pursuant to the regulations.

[(6) Each contract under this section—

[(A) shall provide that the Secretary, or any person or organization designated by him—

[(i) shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under such contract; and

[(ii) shall have the right to audit and inspect any books and records of such health maintenance organization which pertain to services performed and determinations of amounts payable under such contract;

[(B) shall provide that no reinsurance costs (other than costs with respect to out-of-area services and, in the case of an organization which has entered into a risk-sharing contract with the Secretary pursuant to paragraph (2)(A), the cost of providing any member with basic health services the aggregate value of which exceeds $5,000 in any year), including any underwriting of risk relating to costs in excess of adjusted average per capita cost, as defined in clause (iii) of subsection (a)(3)(A), shall be allowed for purposes of determining payments authorized under this section; and

[(C) shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary.

[(j) The function vested in the Secretary by subsection (i) may be performed without regard to such provisions of law or of other regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.]

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

Sec. 1876. (a) (1) The Secretary shall annually determine a per capita rate of payment—

(A) for each class of individuals who are enrolled (in accordance with this section) with a health maintenance organization which has entered into a contract under this section and who are entitled to benefits under Part A and enrolled under part B; and

(B) for each class of individuals who are so enrolled with such an organization and who are enrolled under part B only.

Such rate for each class shall be equal to 95 percent of the adjusted average per capita cost for that class.

(2) For purposes of this section, the term "adjusted average per capita cost" means the average per capita amount that the Secretary estimates (on the basis of actual experience, or retrospective actuarial equivalent based upon an adequate sample and other information and data, in a geographic area served by a health maintenance organization or in a similar area, with appropriate adjustments to assure actuarial equivalence) would be payable in any contract year for services covered under parts A and B, or part B only, and types of expenses otherwise reimbursable under parts A and B, or part B only (including administrative costs incurred by organizations described in sections 1816 and 1842), if the services were to be furnished by other than a health maintenance organization or, in the case of services covered only under section 1861 (s) (2) (G), if the services were to be furnished by a physician or as an incident to a physician's service.

(3) In establishing classes of individuals for purposes of this subsection, the Secretary shall take into consideration such factors as age, sex, institutional status, disability status, and place of residence.

(4) After determining under paragraph (1) the rate of payment to be utilized with respect to a health maintenance organization, the Secretary shall make monthly payments, in advance and in accordance with such rate, except as provided in subsection (i) (2), to such organization for each individual enrolled in accordance with this section with the organization. Such payments shall be in lieu of payments which (the absence of the contract entered into under this section) would be payable otherwise pursuant to section 1814(b) or 1833(a) for services furnished by or through the organization to individuals enrolled with the organization and entitled to benefits under part A and enrolled under part B or enrolled under part B only.

(5) The payment to a health maintenance organization under this subsection for individuals enrolled in accordance with this section with the organization and entitled to benefits under part A and enrolled under part B shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The portion of that payment to the organization for a month to be paid by the latter trust fund shall be equal to 200 percent of the sum of—

(A) the product of (i) the number of such individuals for the month who have attained age 65, and (ii) the monthly actuarial rate for supplementary medical insurance for the month as determined under section 1839(c) (1); and

(*B*) *the product of* (*i*) *the number of such individuals for the month who have not attained age 65, and* (*ii*) *the monthly actuarial rate for supplementary medical insurance for the month as determined under section 1839*(*c*)(*4*).

The remainder of that payment shall be paid by the former trust fund.

(*b*)(*1*) *For purposes of this section, the term "health maintenance organization" means a public or private organization, organized under the laws of any State, which is a qualified health maintenance organization (as defined in section 1310*(*d*) *of the Public Health Service Act) or which—*

(*A*) *provides or otherwise makes available to enrolled participants health care services, including at least the following health care services: physicians' services performed by physicians (as defined in section 1861*(*r*)(*1*), *inpatient hospital services, laboratory, X-ray, emergency, and preventive services, and out of area coverage;*

(*B*) *is compensated (except for deductibles, coinsurance, and copayments) for the provision of health care services to enrolled participants by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health care service actually provided;*

(*C*) *provides physicians' services primarily* (*i*) *directly through physicians who are either employees or partners of such organization, or* (*ii*) *through arrangements with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis);*

(*D*) *assumes full financial risk on a prospective basis for the provision of the health care services listed in subparagraph* (*A*), *except that a health maintenance organization may obtain insurance or make other arrangements—*

(*i*) *for the cost of providing to any enrolled participant health care services listed in subparagraph* (*A*) *the aggregate value of which exceeds $5,000 in any year,*

(*ii*) *for the cost of health care services listed in subparagraph* (*A*) *provided to its enrolled participants other than through the organization because medical necessity required their provision before they could be secured through the organization, and*

(*iii*) *for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year; and*

(*E*) *has made adequate provision against the risk of insolvency, which provision is satisfactory to the Secretary.*

(*2*) *The Secretary may not enter into a contract with a health maintenance organization under this section, unless, with respect to individuals enrolled with the organization under this section, the following requirements are met:*

(*A*) *Benefit Package.—The organization must provide to such individuals who are—*

(*i*) *entitled to benefits under part A and enrolled under part B, only those services covered under parts A and B of this title, or*

(ii) only enrolled under part B, only those services covered under such part,

except that, in addition, the organization may provide such individuals with such additional health care services either as the Secretary may approve or as such individuals may elect, at their option, to have covered. The Secretary shall approve any such additional health care services which the organization proposes to offer to such individuals, unless the Secretary determines that including such additional services will substantially discourage enrollment by covered individuals with the organization.

(B) Limits on Deductibles, Coinsurance, and Copayments.—The amount of any deductibles, coinsurance, and copayments required by such individuals will not exceed the limits applicable under subsection (g) of this section.

(C) Providers.—The organization must provide the services described in subparagraph (A) to such individuals through institutions, entities, and persons meeting the applicable requirements of section 1861.

(D) Open Enrollment.—The organization must have an open enrollment period, for the enrollment of such individuals, of reasonable duration at least every year during which it accepts up to the limits of its capability and without restrictions, except as may be authorized in regulations, individuals who are eligible to enroll under subsection (d) in the order in which they apply for enrollment, unless to do so would result in failure to meet the requirements of subsection (h) or would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the population in the geographic area served by the organization.

(E) Expulsion of Members.—The organization must (i) provide assurances to the Secretary that it will not expel or refuse to reenroll any such individual because of the individual's health status or requirements for health care services, and (ii) notify each such individual of such fact at the time of the individual's enrollment.

(F) Availability of Services.—The organizations must—

(i) make the services described in subparagraph (A) (and such other health care services as such individuals have contracted for) (I) available and accessible to each such individual, within the area served by the organization, promptly as appropriate and in a manner which assures continuity, and (II) when medically necessary, available and accessible twenty-four hours a day and seven days a week, and

(ii) provide for reimbursement with respect to services which are described in clause (i) and which are provided to such an individual other than through the organization, if the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition.

(G) Grievance Procedures.—The organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and such individuals.

(H) QUALITY ASSURANCE.—The organization must have arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for health care services it provides to such individuals, which program (i) stresses health outcomes and (ii) provides review by physicians and other health care professionals of the process followed in the provision of such health care services.

(c) If an individual is enrolled in accordance with this section with a health maintenance organization, only the health maintenance organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.

(d) Subject to the provisions of subsection (e), every individual entitled to benefits under part A and enrolled under part B or enrolled under part B only (other than an individual medically determined to have end-stage renal disease) shall be eligible to enroll under this section with any health maintenance organization with which the Secretary has entered into a contract under this section and which serves the geographic area in which the individual resides.

(e)(1) An individual may enroll under this section with a health maintenance organization as may be prescribed in regulations and may terminate his enrollment with the health maintenance organization as of the beginning of the first calendar month following a full calendar month after the request is made for such termination.

(2) The Secretary may prescribe the procedures and conditions under which a health maintenance organization that has entered into a contract with the Secretary under this subsection may inform individuals eligible to enroll under this section with the organization about the organization, or may enroll such individuals with the organization.

(f) Any individual enrolled with a health maintenance organization under this section who is dissatisfied by reason of his failure to receive any health care service to which he believes he is entitled and at no greater charge than he believes he is required to pay shall, if the amount in controversy is $100 or more, be entitled to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the health maintenance organization a party. If the amount in controversy is $1,000 or more, the individual or health maintenance organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the health maintenance organization shall be entitled to be parties to that judicial review.

(g)(1) In no case may—

(A) the portion of a health maintenance organization's premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (with respect to services covered under parts A and B) to individuals who are enrolled in accordance with this section with the organization and who are entitled to benefits under part A and enrolled under part B, or

(B) the portion of its premium rate and the actuarial value of its deducibles, coinsurance, and copayments charged (with re-

spect to services covered under part B) to individuals who are enrolled in accordance with this section with the organization and enrolled under part B only

exceed the actuarial value of the coinsurance and deductibles that would be applicable on the average to individuals enrolled in accordance with this section with the organization (or, if the Secretary finds that adequate data are not available to determine that actuarial value, other appropriate data) and entitled to benefits under part A and enrolled under part B, or enrolled under part B only, respectively, if they were not members of a health maintenance organization.

(2) If the health maintenance organization provides to its enrollees under this section services in addition to services covered under parts A and B of this title, election of coverage for such additional services (unless such services have been approved by the Secretary under subsection (b)(2)(A)) shall be optional for such enrollees and such organization shall furnish such enrollees with information of the portion of its premium rate or other charges applicable to such additional services. In no case may the sum of—

(A) the portion of such organization's premium rate charged, with respect to such additional services to individuals enrolled in accordance with this section, and

(B) the actuarial value of its deductibles, coinsurance, and copayments charged, with respect to such services, to such individuals

exceed the adjusted community rate for such services.

(3) For purposes of this section, the term "adjusted community rate" for a service means, at the election of a health maintenance organization, either—

(A) the rate of payment for that service which the Secretary annually estimates would apply to an individual enrolled in accordance with this section with the health maintenance organization if the rate of payment were determined under a "community rating system" (as defined in section 1302(8) of the Public Health Service Act, other than subparagraph (C)), or

(B) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to an individual enrolled in accordance with this section with the health maintenance organization, as is attributable to the payment for that service,

but adjusted for differences between the utilization characteristics of the individuals enrolled with the health maintenance organization under this section and the utilization characteristics of the other members of the organization (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of individuals in other health maintenance organizations, or individuals in the area, in the State, or in the United States, eligible to enroll under this section with a health maintenance organization and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

(4) Notwithstanding any other provision of law, the health maintenance organization may (in the case of the provision of services to

an individual enrolled in accordance with this section for an illness or injury for which the member is entitled to benefits under a workman's compensation law or under an automobile insurance policy) charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law or policy—

(A) the insurance carrier, employer, or other entity which under such law or policy is to pay for the provision of such services, or

(B) such member to the extent that such member has been paid under such law or policy for such services.

(h)(1) Except as provided in paragraph (2), each health maintenance organization with which the Secretary enters into a contract under this section shall have, for the duration of such contract, an enrolled membership at least half of which consists of individuals who are not entitled to benefits under this title or under a State plan approved under title XIX.

(2) The Secretary may modify or waive the requirement described in paragraph (1) in circumstances which, as determined by the Secretary, warrant special consideration (and may take into account, in determining whether to modify or waive that requirement, the reasonableness of the organization's premium rate and other charges for members entitled to benefits under this title or under a State plan approved under title XIX); except that the Secretary may make such a modification or waiver only on the condition that the health maintenance organization will not have, for the duration of such contract, an enrolled membership of which one-half or more are individuals entitled to benefits under part A or enrolled under Part B.

(i)(1) The Secretary may enter into a contract with any health maintenance organization, as defined in subsection (b)(1), for the purpose of carrying out this section.

(2) Each contract shall provide that—

(A) if the adjusted community rate, as defined in subsection (g)(3), for services covered under parts A and B (as reduced for the actuarial value of the coinsurance and deductibles under those parts) for individuals enrolled in accordance with this section with the organization and entitled to benefits under part A and enrolled in part B, or

(B) if such adjusted community rate for services under part B (as reduced for the actuarial value of the coinsurance and deductibles under that part) for individuals enrolled in accordance with this section with the organization and enrolled under part B only

is less than the average of the per capita rates of payment to be made under subsection (a)(1) at the beginning of an annual contract period for individuals enrolled in accordance with this section with the organization and entitled to benefits under part A and enrolled in part B, or enrolled in part B only, respectively, the health maintenance organization shall provide to each individual enrolled in accordance with this section with the organization and entitled to benefits under part A and enrolled in part B, or enrolled in part B, respectively, additional benefits which are selected by the health maintenance organization and which the Secretary finds are at least equal in value to the differ-

ence between the average per capita payment and the adjusted community rate (as so reduced); except that this paragraph shall not apply with respect to any organization which elects to receive a lesser payment to the extent that there is no longer a difference between the average per capita payment and adjusted community rate (as so reduced). If the Secretary finds that there is insufficient enrollment experience to determine an average of the per capita rates of payment to be made under subsection (a)(1) at the beginning of a contract period, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this section.

(3) Such additional benefits shall be (A) the reduction of the premium rate or other charges made with respect to services furnished by the organization to individuals enrolled under this section, or (B) the provision of additional health benefits, or both.

(4) The effective date of any contract executed pursuant to this subsection shall be specified in the contract.

(5) Each contract under this section—

(A) shall provide that the Secretary, or any person or organization designated by him—

(i) shall have right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the contract, and

(ii) shall have right to audit and inspect any books and records of the health maintenance organization that pertain (I) to the ability of the organization to bear the risk of potential financial losses, and (II) to services performed or determinations of amounts payable under the contract;

(B) shall require the organization to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this title, to each individual enrolled under this section with the organization; and

(C) shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary.

(6) The Secretary may not enter into contract with a health maintenance organization under this section if a former contract with that organization under this section was terminated at the request of the organization within the preceding five-year period, except in circumstances which warrant special consideration, as determined by the Secretary.

(7) The authority vested in the Secretary by this subsection may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

PENALTIES

SEC. 1877. (a) * * *

(b)(1) Whoever *knowingly and willfully* solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever *knowingly and willfully* offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to pucrhase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

* * * * * * *

HOSPITAL PROVIDERS OF EXTENDED CARE SERVICES

Sec. 1882. (a)(1) Any hospital (other than a hospital which has in effect a waiver of the requirement imposed by section 1861(e)(5)) which has an agreement under section 1866 may (subject to subsection (b)) enter into an agreement with the Secretary under which its inpatient hospital facilities may be used for the furnishing of services of the type which, if furnished by a skilled nursing facility, would constitute post-hospital extended care services.

(2)(A) Notwithstanding any other provision of this title, payment to any hospital for services furnished under an agreement entered into under this section shall be based upon the reasonable cost of the services as determined under subparagraph (B).

(B)(i) The reasonable cost of the services consists of the reasonable cost of routine services (determined under clause (ii)) and the reasonable cost of ancillary services (determined under clause (iii)).

(ii) The reasonable cost of routine services furnished during any calendar year by a hospital under an agreement under this section is equal to the product of (I) the number of patient days during the year for which the services were furnished, and (II) the average reasonable cost per patient-day, such average reasonable cost per patient-day being the average rate per patient-day paid for routine services during the previous calendar year under title XIX to skilled nursing facilities located in the State in which the hospital is located and which have agreements entered into under section 1902(a)(28).

(iii) The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

(b) The Secretary may not enter into an agreement under this section with any hospital unless the hospital has been granted a certificate of need for the provision of long-term care services from the State health planning and development agency (designated under section 1521 of the Public Health Service Act) for the State in which the hospital is located.

(c) An agreement with a hospital under this section shall, except as otherwise provided under regulations of the Secretary, be subject to termination on the same conditions as are agreements with skilled nursing facilities under section 1866 (unless the hospital fails to satisfy the requirements specified in subsection (b)) and shall, where not inconsistent with any provision of this section, impose the same duties, responsibilities, conditions, and limitations, as those imposed under such agreements entered into under section 1866; except that no such agreement with any hospital shall be in effect for any period during which the hospital does not have in effect an agreement under section 1866, or where there is in effect for the hospital a waiver of the requirement imposed by section 1861(e)(5). A hospital whose agreement under this section has been terminated shall not be eligible to undertake a new agreement until a two-year period has elapsed from the termination date.

(d) Any agreement with a hospital under this section shall provide that payment for services will be made only for services for which payment would be made as post-hospital extended care services if those services had been furnished by a skilled nursing facility under an agreement entered into under section 1866; and any individual who is furnished services, for which payment may be made under an agreement under this section, shall, for purposes of this title (other than this section), be deemed to have received post-hospital extended care services in like manner and to the same extent as if the services furnished to him had been post-hospital extended care services furnished by a skilled nursing facility under an agreement under section 1866.

(e) During a period for which a hospital has in effect an agreement under this section, in order to allocate routine costs between hospital and long-term care services for purposes of determining payment for inpatient hospital services, the total reimbursement received for routine services from all classes of long-term care patients (including title XVIII, title XIX, and private pay patients) shall be subtracted from the hospital's total routine costs before calculations are made to determine title XVIII reimbursement for routine hospital services.

(f) A hospital which enters into an agreement with the Secretary under this section shall be required to meet those conditions applicable to skilled nursing facilities relating to discharge planning and the social services function (and staffing requirements to satisfy it) which are promulgated by the Secretary under section 1861(j)(15). Services furnished by such a hospital which would otherwise constitute post-hospital extended care services if furnished by a skilled nursing facility shall be subject to the same requirements applicable to such services when furnished by a skilled nursing facility except for those

requirements the Secretary determines are inappropriate in the case of these services being furnished by a hospital under this section.

(g) The Secretary shall prescribe by regulation an alternative method for determining the amount of the reasonable cost of post-hospital extended care services furnished in a distinct part of a hospital certified as a skilled nursing facility under section 1861 (j) that is the same method as the method prescribed in subsections (a) and (e) for determining the amount of the reasonable cost for such services furnished by a hospital that uses beds interchangeably for either acute or long-term care and shall approve the use of this method when a hospital can demonstrate that its use would contribute significantly to the more efficient or effective administration of this part and would be in the interest of program beneficiaries.

VOLUNTARY CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES

SEC. 1883. (a) The Secretary shall establish a procedure whereby medicare supplemental policies (as defined in subsection (g)) may be certified by the Secretary as meeting minimum standards set forth in subsection (c). Such procedure shall provide an opportunity for any insurer to submit any such policy, and such additional data as the Secretary finds necessary, to the Secretary for his examination and for his certification thereof as meeting the standards set forth in subsection (c). Such certification shall remain in effect, if the insurer files a statement with the Secretary no later than December 31 of each year stating that the policy continues to meet the standards set forth in subsection (c), and if the insurer submits such additional data as the Secretary finds necessary to independently verify the accuracy of such notarized statement. Where the Secretary determines such a policy meets (or continues to meet) the required standards, he shall authorize the insurer to have printed on such policy an emblem which the Secretary shall cause to be designed for use as an indication that a policy has received the Secretary's certification. The Secretary shall provide each State insurance commissioner with a list of all the policies which have received his certification.

(b) Any medicare supplemental policy, including any such policy which is a mail order policy, issued in any State which has established under State law a regulatory program providing for the application of minimum standards with respect to such policies equal to or more stringent than the standards provided for under subsection (c) shall be deemed (for so long as the Secretary finds such State program continues to require compliance with such standards) to meet the standards set forth in subsection (c).

(c) The Secretary shall not certify under this section any medicare supplemental policy for any period, nor continue a certification for any period, unless he finds that for such period such policy—

(1) meets standards set forth by the Secretary with respect to adequacy of coverage (either in a single policy or, in the case of nonprofit hospital and medical service associations, in one or more policies issued in conjunction with one another), but such standards shall not require coverage in excess of coverage of the part A medicare deductible and the following coverage required un-

der section 7(I)(2) of the "MAIC Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act", adopted by the National Association of Insurance Commissioners on June 6, 1979:

(A) coverage of part A medicare eligible expenses for hospitalization to the extent not covered under part A from the 61st day through the 90th day in any medicare benefit period;

(B) coverage of part A medicare eligible expenses incurred as daily hospital charges during use of medicare's lifetime hospital inpatient reserve days;

(C) upon exhaustion of all medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 90 percent of all medicare part A eligible expenses for hospitalization not covered by medicare, subject to a lifetime maximum benefit of an additional 365 days; and

(D) coverage of 20 percent of the amount of medicare eligible expenses under part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket deductible of $200 of such expenses and to a maximum benefit of at least $5,000 per calendar year;

(2) is written in simplified language, and in a form, which can be easily understood by purchasers;

(3) does not limit or preclude liability under the policy for a period longer than 6 months because of a health condition existing before the policy is effective;

(4) contains a prominently displayed "no loss cancellation clause" enabling the insured to return the policy within 30 days of the date of receipt of the policy (or the certificate issued thereunder) with return in full of any premium paid;

(5) can be expected (as estimated for such period, not to exceed one year, to the maximum extent appropriate, on the basis of actual claims experience and premiums for such policy and in accordance with accepted actuarial principles and practices) to return to policyholders in the form of aggregate benefits provided under the policy, at least such percentage of the aggregate amount of premiums collected as the Secretary finds reasonable (taking into account all relevant underwriting and other considerations relating to the design and marketing of such policies) for all group policies and, separately, for all individual policies; and

(6) contains a written statement, in such form as the Secretary may prescribe, for prospective purchasers of such information as the Secretary shall prescribe relating to (A) the policy's premium, coverage in relation to the coverage and exclusions under medicare, and renewability provisions, and (B) the identification of the insurer and its agents.

(d)(1) Whoever knowingly or willfully makes or causes to be made or induces or seeks to induce the making of any false statement or representation of a material fact with respect to the compliance of any policy with the standards set forth in subsection (c) or in regulations promulgated pursuant to such subsection, or with respect to the

use of the emblem designed pursuant to subsection (a), shall be fined not more than $25,000 or imprisoned not more than 5 years, or both.

(2) Whoever falsely assumes or pretends to be acting, or misrepresents in any way that he is acting under the authority of or in association with, the program of health insurance established by this title, or any Federal agency, for the purpose of selling or attempting to sell insurance, or in such pretended character demands, or obtains money, paper, documents, or anything of value, and whoever knowingly permits another person to take such an action or make such a representation on his behalf, shall be fined not more than $25,000 or imprisoned not more than 5 years, or both.

(3)(A) Whoever knowingly sells a health insurance policy to an individual entitled to benefits under part A or enrolled under part B of this title, with knowledge that such policy substantially duplicates health benefits to which such individual is otherwise entitled, other than benefits to which he is entitled under a requirement of State or Federal law (other than this title), shall be fined not more than $25,000 or imprisoned not more than 5 years, or both.

(B) For purposes of this paragraph, benefits which are payable to or on behalf of an individual without regard to other health benefit coverage of such individual, shall not be considered as duplicative.

(C) This paragrapth shall not apply with respect to the selling of a group policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations.

(4)(A) Whoever knowingly, directly or through his agent, mails or causes to be mailed any matter for a prohibited purpose (as determined under subparagraph (B)) shall be fined not more than $25,000 or imprisoned not more than 5 years, or both.

(B) For purposes of subparagraph (A), a prohibited purpose means the advertising, solicitation, or offer for sale of a medicare supplemental policy (or a certificate issued thereunder), or the delivery of such a policy (or a certificate issued thereunder), into any State in which such policy or certificate has not been approved by the State commissioner or superintendent of insurance. For purposes of this subparagraph any medicare supplemental policy (or a certificate issued thereunder) shall be deemed to be approved by the State commissioner or superintendent of insurance of such State if (i) it has been approved by the Secretary or by the commissioners or superintendents of insurance in the States in which more than 30 percent of such policies or certificates are sold, or (ii) such State has in effect a law which the commissioner or superintendent of insurance has determined gives him the authority to review, and to approve, or effectively bar from sale in the State, such policy or certificate; except that such a policy or certificate shall not be deemed to be approved by a State commissioner or superintendent of insurance if such State requests to the Secretary that such policy or certificate be subject to such State's approval.

(C) This paragraph shall not apply in the case of a person who mails or causes to be mailed a medicare supplemental policy (or certifi-

cate issued thereunder) into a State if such person has ascertained that the party insured under such policy to whom (or on whose behalf) such policy or certificate is mailed is located in such State on a temporary basis.

(D) This paragraph shall not apply in the case of a person who mails or causes to be mailed a duplicate copy of a medicare supplemental policy (or of a certificate issued thereunder) previously issued to the party to whom (or on whose behalf) such duplicate copy is mailed, if such policy or certificate expires not more than 12 months after the date on which the duplicate copy is mailed.

(e) The Secretary shall provide to all individuals entitled to benefits under this title (and to the extent feasible, individuals about to become so entitled) such information as will permit such individuals to evaluate the value of medicare supplemental policies to them and the relationship of any such policies to benefits provided under this title.

(f)(1)(A) The Secretary shall, in consultation with Federal and State regulatory agencies, the National Association of Insurance Commissioners, private insurers, and organizations representing consumers and the aged, conduct a comprehensive study and evaluation of the comparative effectiveness of various State approaches to the regulation of medicare supplemental policies in (i) limiting marketing and agent abuse, (ii) assuring the dissemination of such information to individuals entitled to benefits under this title (and to other consumers) as is necessary to permit informed choice, (iii) promoting policies which provide reasonable economic benefits for such individuals, (iv) reducing the purchase of unnecessary duplicative coverage, (v) improving price competition, and (vi) establishing effective State programs as described in subsection (b).

(B) Such study shall also adress the need for standards or certification of health insurance policies sold to individuals eligible for benefits under this title, other than medicare supplemental policies.

(C) The Secretary shall, no later than July 1, 1981, submit a report to the Congress on the results of such study and evaluation, accompanied by such recommendations as the Secretary finds warranted by such results with respect to the need for legislative or administrative changes to accomplish the objectives set forth in subparagraphs (A) and (B), including the need for a mandatory Federal regulatory program to assure the marketing of appropriate types of medicare supplemental policies, and such other means as he finds may be appropriate to enhance effective State regulation of such policies.

(2) The Secretary shall submit to the Congress on January 1, 1982, and periodically as may be appropriate thereafter (but not less often than once every 2 years), a report evaluating the effectiveness of the certification procedure and the criminal penalties established under this section, and shall include in such reports an analysis of—

(A) the impact of such procedure and penalties on the types, market share, value, and cost to individuals entitled to benefits under this title of medicare supplemental policies which have been certified by the Secretary;

(B) the need for any changes in the certification procedure to improve its administration or effectiveness; and

(C) whether the certification program and criminal penalties should be continued.

(g) For purposes of this section, a medicare supplemental policy is a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this title, which provides reimbursement for expenses incurred for services and items for which payment may be made under this title but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed pursuant to this title; but does not include any such policy or plan of one or more employers or labor organizations, or of the trustees of a funds established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations.

(h) The Secretary shall prescribe such regulations as may be necessary for the effective, efficient, and equitable administration of the certification procedure established under this section.

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

Sec. 1902. (a) A State plan for medical assistance must—

(1) * * *

* * * * * *

(9) provide—

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purposes specified in the first sentence of section 1864 (a)), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services, [and]

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions[;], *and*

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the requirements of section 1861(e)(9) or paragraphs (10) and (11) of section 1861(s);

(10) provide—

(A) for making medical assistance available to all individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI;

(B) that the medical assistance made available to any individual described in clause (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in clause (A); and

(C) if medical assistance is included for any group of individuals who are not described in clause (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under title XVI, as the case may be, as determined in accordance with standards prescribed by the Secretary—

(i) for making medical assistance available to all individuals who would, except for income and resources, be eligible for aid or assistance under any such State plan or to have paid with respect to them supplemental security income benefits under title XVI, and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services, and

(ii) that the medical assistance made available to all individuals not described in clause (A) shall be equal in amount, duration, and scope;

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1905(a) to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of title XVIII to individuals eligible therfor (either pursuant to an agreement entered into under section 1843 or by reason of the payment of premiums under such title by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of title XVIII for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, [and] (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary, with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in

clause (A), *and (IV) the making available of medical assistance to individuals described in section 1902(i) shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of services of the same amount, duration, and scope, to any other individuals*;

* * * * * * *

(13) provide—

(A)(i) for the inclusion of some institutional and some noninstitutional care and services, and

(ii) for the inclusion of home health services for any individual who, under the State plan, is entitled to skilled nursing facility services, and

(B) in the case of individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, for the inclusion of at least the care and services listed in [clauses (1) through (5)] *paragraphs (1) through (5) and (17)* of section 1905(a), and

(C) in the case of individuals not included under subparagraph (B) for the inclusion of at least—

(i) the care and services listed in [clauses (1) through (5)] *paragraphs (1) through (5) and (17)* of section 1905(a) or

(ii)(I) the care and services listed in any 7 of the [clauses numbered (1) through (16)] *paragraphs numbered (1) through (17)* of such section and (II) in the event the care and services provided under the State plan include hospital or skilled nursing facility services, physicians' services to an individual in a hospital or skilled nursing facility during any period he is receiving hospital services from such hospital or skilled nursing facility services from such facility, and

(D) for payment of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards, consistent with section 1122, which shall be developed by the State and reviewed and approved by the Secretary and (after notice of approval by the Secretary) included in the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1861(v) as the reasonable cost of such services for purposes of title XVIII, *except that in the case of hospitals reimbursed for services under part A of title XVIII in accordance with section 1814(b)(3), the plan must provide for payment of inpatient hospital services provided in such hospitals under the plan in accordance with the reimbursement system used under such section*; and

* * * * * * *

(14) effective January 1, 1973, provide that—

(A) in case of individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or

XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or who meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under title XVI, as the case may be, and individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in paragraph (10)(A)—

(i) no enrollment fee, premium, or similar charge, and no deduction, cost sharing, or similar charge with respect to the care and services listed in [clauses (1) through (5) and (7)] *paragraphs (1) through (5), (7), and (17)* of section 1905(a), will be imposed under the plan, and

* * * * * * *

(17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this title, (B) provide for taking into account (*except as provided under subsection (j)*) only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or to have paid with respect to him supplemental security income benefits under title XVI) as would not be disregarded (or set aside for future needs) in determining his eligibilty for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, [and] (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under title XVI), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1614 (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with re-

spect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law, *and (E) in the case of individuals who have disabilities which are sufficiently severe to result in functional limitations requiring medical assistance in order that they may work, provide for the exclusion from income of such amounts as may be excluded by classes (ii) through (iv) of section 1612(b)(4)(B) (as added by Supplemental Security Income Disability Amendments of 1979) from the determination of income under title XVI*;

* * * * * * *

(23) except in the case of Puerto Rico, the Virgin Islands, and Guam, provided that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a pre-payment basis), who undertakes to provide him such services; and a State plan shall not be deemed to be out of compliance with the requirements of this paragraph or paragraph (1) or (10) solely by reason of the fact that the State (or any political subdivision thereof) (*A*) has entered into a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization, or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic , *or (B) during the three-year period beginning on the date of enactment of this clause, has made arrangements through a competitive bidding process or otherwise for the purchase of laboratory services referred to in section 1905(a)(3), if the Secretary has found that (i) adequate services will be available under such arrangements, (ii) such laboratory services will be provided only through laboratories (I) which meet the requirements of the section 1861(e)(9) or paragraphs (10) and (11) of section 1861(s), and such additional requirements as the Secretary may require, (II) no more than 75 percent of whose charges for such services are for services provided to individuals who are entitled to benefits under this title or under part A or part B of title XVIII, and (iii) charges for services provided under such arrangements are made at the lowest rate charged (determined without regard to administrative costs which are related solely to the method of reimbursement for such services) for comparable services by the provider of such services, or, if charged for on a unit price basis, such charges result in aggregate expenditures not in excess of expenditures that would be made if charges were at the lowest rate charged for comparable services by the provider of such services* ;

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(33) provide—

(A) that the State health agency, or other appropriate state medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of medical assistance under the plan in order to provide guidance with respect thereto in the administration of the plan to the State agency established or designated pursuant to paragraph (5) and, where applicable, to the State agency described in the penultimate sentence of this subsection; and

(B) that the State or local agency utilized by the Secrtary for the purpose specified in the first sentence of section 1864(a), or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform for the State agency administering or supervising the administration of the plan approved under this title the function of determining whether institutions and agencies meet the requirements for participation in the program under such plan, *except that the Secretary is authorized to validate State determinations and, on that basis, make independent and binding determinations concerning the extent to which individual institutions and agencies meet the requirements for participation;*

* * * * * * *

[(35) provide that any intermediate care facility receiving payments under such plan complies with the requirements of section 1124;]

(35) provide that any disclosing entity (as defined in section 1124(a)(2)) receiving payments under such plan complies with the requirements of section 1124;

* * * * * * *

[(39) provide that, subject to subsection (g), whenever the single State agency which administers or supervises the administration of the State plan is notified by the Secretary under section 1862(e)(2)(A) that a physician or other individual practitioner has been suspended from participation in the program under title XVIII, the agency shall promptly suspend such physician or practitioner from participation in the plan for not less than the period specified in such notice, and no payment may be made under the plan with respect to any item or service furnished by such physician or practitioner during the period of the suspension under this title; and]

(39) provide that the State agency shall bar any specified individual from participation in the program under the State plan for the period specified by the Secretary, when required by him to do so pursuant to section 1127, and provide that no payment may be made under the plan with respect to any item or service furnished by such indivdual during such period;

(40) require each health services facility or organization which receives payments under the plan and of a type for which a uniform reporting system has been established under section 1121(a) to make reports to the Secretary of information described in such section in accordance with the uniform reporting system (established under such section) for that type of facility or organization[.]*;*

(41) provide (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that such audits, for such entities also providing services under title XVIII, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such part, and (C) for payment of such proportion of costs of each such common audit as is determined under methods specified by the Secretary under section 1128(a); and

(42) if the State plan makes provision for payment to a physician for laboratory services the performance of which such physician (or any other physician with whom he shares his practice) did not personally perform or supervise, include provision to insure that payment under the State plan for such laboratory services not exceed the payment authorized for such services by section 1842(h).

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this title, the State agency which administered or supervised the administration of the plan of such State approved under title X (or title XVI, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under title I (or title XVI, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under title X (or title XVI, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this title (except for purposes of paragraph (10)).

For purposes of paragraphs (9)(A), (29), (31), and (33), and of section 1903(i)(4), the term "skilled nursing facility" and "nursing home" do not include a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

For purposes of paragraph (10) any individual who, for the month of August 1972, was eligible for or receiving aid or assistance under a State plan approved under title I, X, XIV, or XVI, or part A of title IV and who for such month was entitled to monthly insurance benefits

under title II shall for purposes of this title only be deemed to be eligible for financial aid or assistance for any month thereafter if such individual would have been eligible for financial aid or assistance for such month had the increase in monthly insurance benefits under title II resulting from enactment of Public Law 92–336 not been applicable to such individual. *In the case of an individual who, for a month after May 1980, was determined to be eligible for medical assistance under the plan and was receiving a monthly insurance benefit under title II of this Act or under the Railroad Retirement Act of 1974 or an annuity under subchapter III of chapter 83 of title 5, United States Code (relating to civil service retirement), or compensation, dependency and indemnity compensation, or a pension, under chapter 11, 13, or 15 of title 38, United States Code (relating to veterans and other persons) and who (but for this sentence) would have become ineligible for such medical assistance in the subsequent month because of an increase in the amount of such benefit or annuity due to an increase in a cost-of-living or price index, or because of an annual, general increase in the amount of such compensation or pension, respectively, becoming effective in such subsequent month, for purposes of establishing the individual's eligibility for medical assistance under the plan for such subsequent month (and each month thereafter until the first month in which the individual otherwise becomes ineligible for such assistance) there shall not be included in the individual's income any such increase in the amount of such benefit, annuity, compensation, or pension which becomes effective in or after such subsequent month.*

The requirement of clause (A) of paragraph (37) with respect to a State plan may be waived by the Secretary if he finds that the State has exercised good faith in trying to meet such requirement.

* * * * * * *

[(g) The Secretary may waive suspension under subsection (a) (39) of a physician's or practitioner's participation in a State plan approved under this title and of the prohibition under such subsection of payment for any item or service furnished by him during the period of such suspension, if the single State agency which administers or supervises the administration of the plan submits a request to the Secretary for such waiver and if the Secretary approves such request.]

(h) (1) In addition to any other authority under State law, where a State determines that a skilled nursing facility or intermediate care facility which is certified for participation under its plan no longer substantially meets the provisions of section 1861(j) or section 1903 (c), respectively, and further determines that the facility's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the State shall provide for the termination of the facility's certification for participation under the plan and may provide, or

(B) do not immediately jeopardize the health and safety of its patients, the State may, in lieu of providing for terminating the facility's certification for participation under the plan, provide

that no payment will be made under the State plan with respect to any individual admitted to such facility after a date specified by the State.

(2) The State shall not make such a decision with respect to a facility until the facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the provisions of section 1861(j) or section 1903(c) (as the case may be), to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

(3) The State's decision to deny payment may be made effective only after such notice to the public and to the facility as may be provided for by the State, and its effectiveness shall terminate (A) when the State finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the provisions of section 1861(j) or section 1905(c) (as the case may be), or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of the respective section on the date specified in such clause, the State shall terminate such facility's certification for participation under the plan effective with the first day of the first month following the month specified in such clause.

(i) For purposes of this title, an individual shall be treated as an individual eligible for medical assistance under subsection (a)(10)(A) if—

(1) supplemental security income benefits under title XVI would be payable with respect to the individual but for paragraph (4) of section 1611(e) (as added by the Supplemental Security Income Disability Amendments of 1979), or

(2) the individual is determined (in accordance with standards established by the Secretary)—

(A) to have a severe medical disability and to meet, except for the individual's earnings, all non-disability-related requirements for eligibility to have supplemental security income benefits paid with respect to the individual under title XVI;

(B) to have an income which does not, except for earnings, exceed the amount which would cause the individual to be ineligible for payments under section 1611(b) (if the individual were otherwise eligible for such payments);

(C)(i) to have been receiving medical assistance under this title (as an individual eligible or considered eligible for such assistance under subsection (a)(10)(A)), (ii) without a determination under this paragraph the individual would not be eligible for continuation of such assistance, and (iii) the termination of such eligibility would seriously inhibit the individual's ability to continue employment; and

(D) to have earnings which are not sufficient to allow the individual to provide for himself a reasonable equivalent of the benefits which would be available to the individual, in the absence of such earnings, under this title and title XVI.

For purposes of this subsection, an individual shall be considered to have a severe medical disability if the individual's impairment is suf-

ficiently severe to result in a functional limitation requiring medical assistance in order for the individual to work.

(j)(1) Notwithstanding any other provision of this title (including subsection (f), but except as provided in paragraphs (2) and (4)) and to the extent permitted in this subsection, a State plan for medical assistance under this title may provide that an individual shall be ineligible for medical assistance, provided under a State plan approved under this title, for the period specified in paragraph (2) if—

(A) within any twenty-four-month period that begins with or after the twenty-fourth month preceding the month in which he files an application for medical assistance under the plan, the individual (or another person whose resources are considered in determining the eligibility of the individual) disposed of resources which, if retained, would have caused the individual to be ineligible for such assistance, for the purpose of establishing eligibility for such benefits (and any disposition of resources within such period may be presumed to have been for such purpose unless the State is furnished convincing evidence that the transaction was for some other purpose), and

(B) the sum of—

(i) the current market value of the individual's (or other person's) equity interest in such resources disposed of without any compensation, and

(ii) the difference between the current market value of the individual's (or person's) equity interest in such resources disposed of for compensation and the amount of such compensation,

exceeded $6,000.

(2)(A) Except as provided in subparagraph (B), the period for which an individual is eligible for medical assistance under a State plan by reason of the application of paragraph (1) shall be—

(i) six months, if the sum described in paragraph (1)(B) is less than $12,000,

(ii) twelve months, if the sum described in paragraph (1)(B) exceeded $12,000 but was less than $30,000, and

(iii) twenty-four months, if the sum described in paragraph (1)(B) exceeded $30,000,

and shall begin with the month following the month in which such disposition occurred.

(B) A period of ineligibility shall end after the month in which the individual (or other person) either (i) returns the resources, the disposition of which caused the ineligibility to occur or (ii) receives payment equal to the amount of any uncompensated interest described in paragraph (1)(B).

(C) A State plan may provide for the waiver of the requirement of paragraph (1), or the reduction in the period of ineligibility imposed by this paragraph, in such cases as the State determines that such a waiver or reduction is justified.

(3) If the eligibility of a person for medical assistance under this title is dependent upon the eligibility of another individual and that other individual is determined to be ineligible for medical assistance

under paragraph (1) for a period of time, the person shall be ineligible for medical assistance for the same period of time.

(4)(A) Except as provided in subparagraph (B), paragraph (1) shall not apply to individuals with respect to whom supplemental security income benefits are being paid under title XVI.

(B) Subparagraph (A) shall not apply to a State which, pursuant to subsection (f), does not provide for medical assistance to all individuals with respect to whom supplemental security income benefits are being paid under title XVI.

(5)(A) Notwithstanding any other provision of law, if an individual disposes of resources to another person which disposal, under this subsection, could make the individual ineligible for medical assistance from a State for a period, the State plan under this title may provide for the recovery from such other person of an amount equal to—

(i) the cost of the medical assistance provided to the individual during or after such period, or

(ii) the sum described in clauses (i) and (ii) of paragraph (1)(B) with respect to transactions between the individual and the person for such period,

whichever is less, except that the State may not not initiate such an action for recovery more than three years after the last date in such period of ineligibility.

(B) If a State recovers funds under subparagraph (A), it shall provide for notice to the Secretary of the amounts so recovered and the Secretary shall reduce the amount of payments otherwise provided to the State under this title by an amount equal to product of—

(i) the amount so recovered, and

(ii) the Federal medical assistance percentage of the State.

PAYMENTS TO STATES

SEC. 1903. (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966—

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b), subject to subsections (g) [and (h)], *(h), and (j)* of this section) of the total amount expended during such quarter as medical assistance under the State plan (including expenditures for premiums under part B of title XVIII, for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), and, except in the case of individuals sixty-five years of age or older and disabled individuals entitled to hospital insurance benefits under title XVIII or who are not enrolled under part B of title XVIII, other insur-

ance premiums for medical or any other type of remedial care or the cost thereof); plus

* * * * * * *

(4) an amount equal to 100 per centum of the sums expended with respect to costs incurred during such quarter *and before October 1, 1983* (as found necessary by the Secretary for the proper and efficient administration of the State plan) which are attributable to compensation or training of personnel (of the State agency or any other public agency) responsible for inspecting public or private institutions (or portions thereof) providing long-term care to recipients of medical assistance to determine whether such institutions comply with health or safety standards applicable to such institutions under this Act; plus

* * * * * * *

(6) subject to subsection (b)(3), [an amount equal to 90 per centum of the sums expended during each quarter beginning on or after October 1, 1977, and ending before October 1, 1980, with respect to costs incurred]
an amount equal to—

(A) 90 per centum of the sums expended during such a quarter within the twelve-quarter period beginning with the first quarter in which a payment is made to the State pursuant to this paragraph, and

(B) 75 per centum of the sums expended during each succeeding calendar quarter,

with respect to cost incurred during such quarter (as found necessary by the Secretary for the elimination of fraud in the provision and administration of medical assistance provided under the State plan) which are attributable to the establishment and operation of (including the training of personnel employed by) a State medicaid fraud control unit (described in subsection (q)); plus.

(7) an amount equal to 90 per centum of the sums expended during such quarter which are attributable to the performance of a second or third opinion as to necessity and appropriateness of specified elective surgical procedures described in section 1130 (f)(1)(B); plus

[(7)](*8*) an amount equal to 50 per centum of the remainder of the amounts expended such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

(d)(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsections (a) and (b) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsections, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the

source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

(2) (*A*) The Secretary shall then pay to the State, in such installments as he may determine, the amounts so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection. Expenditures for which payments were made to the State under subsection (a) shall be treated as an overpayment to the extent that the State or local agency administering such plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with section 1902 (a) (25). *In determining the installments of payments to be made under this paragraph, the Secretary shall insure that payments to States are not made before the time that checks issued by the State for the medical assistance or other expenditure for which the Federal payment is being made are cleared through the State depository for payment, and the Secretary shall provide that each State may, with the approval of the Secretary, designate an estimating procedure to be used to determine the amount of the Federal payment under this sentence.*

(*B*) *In any State which has in its Constitution a provision prohibiting the issue of checks or warrants by State officials unless there are funds in the State Treasury to pay for them, the Secretary shall reduce the amount of payment otherwise obligated to be made to the State under this title by an amount equal to the amount of the interest on Federal funds held by the State in the period of time before the time the check or warrant is cleared through the State depository for payment. Such amount of interest shall be determined each calendar quarter and shall be based on the average of the bond equivalent of the weekly 90-day Treasury bill auction rates for the four most recent weekly auctions preceding the beginning of the quarter, less the reasonable cost of banking services.*

(g) (1) * * *

* * * * * * *

(3) (A) No reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under this subsection shall take effect—

(i) if such reduction is due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning before January 1, 1977;

(ii) before January 1, 1978;

(iii) unless a notice of such reduction has been provided to the State at least 30 days before the date such reduction takes effect; or

(iv) due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning after September 30, 1977, unless notice of such reduction has been provided to the State no later than the first day of the fourth calendar quarter following the calendar quarter with respect to which such showing was made.

(B) The Secretary shall waive application of any reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under paragraph (1) because a showing by the State,

made under such paragraph with respect to a calendar quarter ending after January 1, 1977, and before [October 1, 1977,] *January 1, 1978*, is determined to be either unsatisfactory under such paragraph or invalid under paragraph (2), if the Secretary determines that the State's showing made under paragraph (1) with respect to [the calendar quarter ending on December 31, 1977] *any calendar quarter ending on or before December 31, 1978*, is satisfactory under such paragraph and is valid under paragraph (2).

* * * * * * *

(i) Payment under the preceding provisions of this section shall not be made—

(1) with respect to any amount paid for items or services furnished under the plan after December 31, 1972, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under the fourth [and fifth], *fifth, and ninth* sentences of section 1842(b)(3); or

* * * * * * *

[(j)(1) Notwithstanding the preceding provisions of this section, no payment shall be made to a State (except as provided under this subsection) with respect to expenditures incurred by it for services provided by any institution during any period that an order for suspension of payment (as authorized by this subsection) is effective with respect to such institution.

[(2) The Secretary may issue a suspension of payment order with respect to any institution if—

[(A) such institution (i) does not (at the time such order is issued) have in effect an agreement with the Secretary which is entered into pursuant to section 1866; and (ii) did (prior to the time such order is issued) have in effect such an agreement; and

[(B)(i) The Secretary has been unable to collect (or make satisfactory arrangement for the collection of) amounts due on account of overpayments made to such institution under title XVIII; or

[(ii) the Secretary has been unable to obtain from such institution the data and information necessary to enable him to determine the amount (if any) of the overpayments made to such institution under title XVIII.

[(3) Whenever the Secretary issues any order for suspension of payment under this subsection with respect to any institution, he shall submit a notice of such order to the single State agency (referred to in section 1902(a)(5)) of each State which he has reason to believe does or may utilize the services of such institution in providing medical assistance under a plan approved under this title.

[(4) Any order for suspension of payment issued with respect to any institution under this subsection shall become effective, in the case of any State plan approved under this title, on the 60th day after the date the State agency (referred to in section 1902(a)(5)) administering or supervising the administration of such plan receives notice of such order submitted pursuant to paragraph (3). Any such order shall cease to be effective at such time as the Secretary is satisfied that the institution is participating in substantial negotiations which seek to

remedy the conditions which gave rise to his order of suspension of payments, or that the amounts (referred to in paragraph (2)) are no longer due from such institution or that a satisfactory arrangement has been made for the payment by such institution of any such amounts. Upon the determination of the Secretary that any such order with respect to any such institution shall cease to be effective, he shall forthwith notify each State agency to which he has theretofore submitted notice under paragraph (3) with respect to such institution.

[(5) Whenever any order which has been issued by the Secretary under the preceding provisions of this subsection with respect to an institution ceases to be effective, any payment to which any State would (except for the preceding provisions of this subsection) have been entitled under this section on account of services provided by such institution shall be made to such State for the month in which such order ceases to be effective.]

(j) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter shall be adjusted in accordance with section 1913.

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(n) The State agency may refuse to enter into any contract or agreement with a hospital, nursing home, or other institution, organization, or agency for purposes of participation under the State plan, or otherwise to approve an institution, organization, or agency for such purposes, if any person, who has a direct or indirect ownership or control interest of 5 percent or more in such institution, organization, or agency, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of such institution, organization, or agency, is a person described in section 1126(a) (whether or not such institution, organization, or agency has in effect an agreement entered into with the Secretary pursuant to section 1866 [or is subject to a suspension of payment order issued under subsection (j)] of this section; and, notwithstanding any other provision of this section, the State agency may terminate any such contract, agreement, or approval if it determines that the institution, organization, or agency did not fully and accurately make any disclosure required of it by section 1126(a) at the time such contract or agreement was entered into or such approval was given.

* * * * * * *

DEFINITIONS

SEC. 1905. The purposes of this title—

(a) The term "medical assistance" means payment of part or all of the costs of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described

in section 1902(a)(10)(A)) not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or Part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, who are

(i) under the age of 21,

(ii) relatives specified in section 406(b)(1) with whom a child is living if such child, except for section 406(a)(2), is (or would, if needy, be) a dependent child under part A of title IV,

(iii) 65 years of age or older,

(iv) blind, with respect to States eligible to participate in the State plan program established under title XVI,

(v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under title XVI,

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under title I, X, XIV, or XVI, [or]

(vii) blind or disabled as defined in section 1614, with respect to States not eligible to participate in the State plan program established under title XVI, *or*

(viii) individuals who have impairments sufficiently severe to result in a functional limitation requiring assistance for the provision of such care and services in order for the individuals to work,

but whose income and resources are insufficient to meet all of such cost—

(1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases);

* * * * * * *

(16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h); [and]

(17) services furnished by a nurse-midwife (as defined in subsection (m)) which he is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not he is under the supervision of, or associated with, a physician or other health care provider; and

[(17)] *(18)* any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary;

except as otherwise provided in paragraph (16), such term does not include—

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution), or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases.

For purposes of clause (vi) of the preceding sentence, a person shall be considered essential to another individual if such person is the spouse of and is living with such individual, the needs of such person

are taken into account in determining the amount of aid or assistance furnished to such individual (under a State plan approved under title I, X, XIV, or XVI), and such person is determined, under such a State plan, to be essential to the well being of such individual.

(b) The term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that [(1)] the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum [, and (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, and Guam shall be 50 per centum]. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of subparagraph (B) of section 1110(a)(8). Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act).

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(m) The term "nurse-midwife" means a registered nurse who has successfully completed a program of study and clinical experience meeting guidelines prescribed by the Secretary, or has been certified by an organization recognized by the Secretary, and performs services in the area of management of the care of mothers and babies (throughout the maternity cycle) which he is legally authorized to perform in the State in which he performs such services.

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CERTIFICATION AND APPROVAL OF SKILLED NURSING FACILITIES AND OF RURAL HEALTH CLINICS

SEC. 1910. (a) * * *

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(c)(1) The Secretary may cancel approval of any skilled nursing or intermediate care facility at any time if he finds on the basis of a determination made by him as provided in section 1902(a)(33)(B) that a facility fails to meet the requirements contained in section 1902(a)(28) or section 1905(c), or if he finds grounds for termination of his agreement with the facility pursuant to section 1866(b). In that event the Secretary shall notify the State agency and the skilled nursing facility or intermediate care facility that approval of eligibility of the facility to participate in the programs established by this title and title XVIII shall be terminated at a time specified by the Secretary. The approval of eligibility of any such facility to participate in such programs may not be reinstated unless the Secretary finds that the reason for termination has been removed and there is reasonable assurance that it will not recur.

(2) Any skilled nursing facility or intermediate care facility which is dissatisfied with a determination by the Secretary that it no longer qualifies as a skilled nursing facility or intermediate care facility for purposes of this title, shall be entitled to a hearing by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). Any agreement between such facility and the State agency shall remain in effect until the period for filing a request for a hearing has expired or, if a request has been filed, until a decision has been made by the Secretary; except that the agreement shall not be extended if the Secretary makes a written determination, specifying the reasons therefor, that the continuation of provider status constitutes an immediate and serious threat to the health and safety of patients, and the Secretary certifies that the facility has been notified of its deficiencies and has failed to correct them.

WITHHOLDING OF FEDERAL SHARE OF PAYMENTS FOR CERTAIN MEDICARE PROVIDERS

SEC. 1913. (a) The Secretary may adjust, in accordance with this section, the Federal matching payment to a State with respect to expenditures for medical assistance for care or services furnished in any quarter by—

(1) an institution (A) which has or previously had in effect an agreement with the Secretary under section 1866; and (B) (i) from which the Secretary has been unable to recover overpayments made under title XVIII, or (ii) from which the Secretary has been unable to collect the information necessary to enable him to determine the amount (if any) of the overpayments made to such institution under title XVIII; and

(2) any person (A) who (i) has previously accepted payment on the basis of an assignment under section 1842(b)(3)(B)(ii), and (ii) during the annual period immediately preceding such quarter submitted no claims for payment under title XVIII, or submitted claims for payment under title XVIII which aggregated less than the amount of overpayments made to him, and (B) (i) from whom the Secretary has been unable to recover overpayments received in violation of the terms of such assignment, or (ii) from whom the Secretary has been unable to collect the information necessary to enable him to determine the amount (if any) of the overpayments made to such person under title XVIII.

(b) The Secretary may (subject to the remaining provisions of this section) reduce payment to a State under this title for any quarter by an amount equal to the lesser of the Federal matching share of payments to any institution or person specified in subsection (a), or the total overpayments to such institution or person under title XVIII, and may require the State to reduce its payment to such institution or person by such amount.

(c) The Secretary shall not make any adjustment in the payment to a State, nor require any adjustment in the payment to an institution or person, pursuant to subsection (b) until after he has provided

adequate notice (which shall be not less than 60 days) to the State agency and the institution or person.

(d) The Secretary shall by regulation provide procedures for implementation of this section, which procedures shall (1) determine the amount of the Federal payment to which the institution or person would otherwise be entitled under this section which shall be treated as a setoff against overpayments under title XVIII, and (2) assure the restoration to the institution or person of amounts withheld under this section which are ultimately determined to be in excess of overpayments under title XVIII and to which the institution or person would otherwise be entitled under this title.

(e) The Secretary shall restore to the trust funds established under sections 1817 and 1841, as appropriate, amounts recovered under this section as setoffs against overpayments under title XVIII.

(f) Notwithstanding any other provision of this title, an institution or person shall not be entitled to recover from any State any amount in payment for medical care and services under this title which is withheld by the State agency pursuant to an order by the Secretary under subsection (b).

HOSPITAL PROVIDERS OF SKILLED NURSING AND INTERMEDIATE CARE SERVICES

SEC. 1914. (a) Notwithstanding any other provision of this title, payment may be made, in accordance with this section, under a State plan approved under this title for skilled nursing facility services and intermediate care facility services furnished by a hospital which has in effect an agreement under section 1882.

(b) (1) Payment to any such hospital, for any skilled nursing or intermediate care facility services furnished, shall be at a rate equal to the average rate per patient-day paid for routine services during the previous calendar year under this title to skilled nursing and intermediate care facilities located in the State in which the hospital is located. The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

(2) With respect to any period for which a hospital has an agreement under section 1882, in order to allocate routine costs between hospital and long-term care services, the total reimbursement for routine services received from all classes of long-term care patients (including title XVIII, title XIX, and private pay patients) shall be subtracted from the hospital total routine costs before calculations are made to determine title XIX reimbursement for routine hospital services.

(c) The State plan may provide an alternative method for determining the amount of payment for long-term care services furnished in a distinct part of a hospital (where the conditions described in section 1882(g) are met) that is the same as the method prescribed in subsection (b) of this section for determining the amount of payment for such services furnished by a hospital that uses beds interchangeably for either acute or long-term care.

* * * * * * *

Section 3 of Public Law 95–210

AN ACT to amend titles XVIII and XIX of the Social Security Act to provide payment for rural health clinic services, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

* * * * * * *

DEMONSTRATION PROJECTS FOR PHYSICIAN-DIRECTED CLINICS IN URBAN MEDICALLY UNDERSERVED AREAS

SEC. 3. (a) * * *

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(e) As used in this section, the terms "physician assistant" and "nurse practitioner" have the meanings given such terms in section 1861[(aa)(3)](*bb*) of the Social Security Act.

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Section 249B of the Social Security Amendments of 1972

PAYMENTS TO STATES UNDER MEDICAID FOR COMPENSATION OF INSPECTORS RESPONSIBLE FOR MAINTAINING COMPLIANCE WITH FEDERAL STANDARDS

SEC. 249B. Section 1903(a) of the Social Security Act, as amended by sections 207(a)(2) and 235(a) of this Act, is further amended, effective for the period beginning October 1, 1972, [and ending September 30, 1980,] by redesignating paragraph (4) as paragraph (5), and by inserting after paragraph (3) the following new paragraph:

"(4) an amount equal to 100 per centum of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) which are attributable to compensation or training of personnel (of the State agency or any other public agency) responsible for inspecting public or private institutions (or portions thereof) providing long-term care to recipients of medical assistance to determine whether such institutions comply with health or safety standards applicable to such institutions under this Act; plus".

○